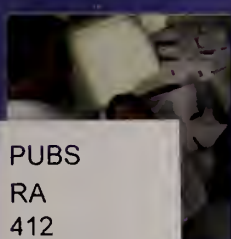
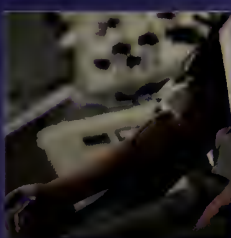




MEDICARE

Resident & New Physician Guide

Helping Health Care Professionals Navigate Medicare



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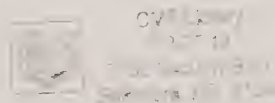
Helping Health Care Professionals Navigate Medicare

Seventh Edition – August 2003

DISCLAIMER

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PREFACE

Medicare

Title XVIII of the Social Security Act, designated "Health Insurance for the Aged and Disabled," is commonly known as Medicare. As part of the Social Security Amendments of 1965, the Medicare legislation established a health insurance program for aged persons to complement the retirement, survivors, and disability insurance benefits under Title II of the Social Security Act.

When first implemented in 1966, Medicare covered most persons age 65 or over. In 1973, the following groups also became eligible for Medicare benefits: persons entitled to Social Security or Railroad Retirement disability cash benefits for at least 24 months, most persons with End-Stage Renal Disease (ESRD), and certain otherwise noncovered aged persons who elect to pay a premium for Medicare coverage. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (Public Law 106-554) allowed persons with Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease) to waive the 24-month waiting period.

Medicare has traditionally consisted of two parts: hospital insurance (HI), also known as Part A, and supplemental medical insurance (SMI), also known as Part B. A new, third part of Medicare, sometimes known as Part C, is the Medicare + Choice Program which was established by the Balanced Budget Act of 1997 (Public Law 105-33 or "BBA") and which expanded beneficiaries' options for participation in private-sector healthcare plans. When Medicare began on July 1, 1966, approximately 19 million people enrolled. In 2001, about 40 million people were enrolled in one or both of Parts A and B of the Medicare Program, and 5.7 million of them chose to participate in a Medicare + Choice plan.

Contractors

Medicare's HI and SMI fee-for-service claims are processed by nongovernmental organizations or agencies that contract to serve as the fiscal agent between providers and suppliers and the Federal Government. These claims processors are known as intermediaries and carriers. They apply the Medicare coverage rules to determine the appropriateness of claims.

Medicare intermediaries process HI claims for institutional services, including inpatient hospital claims, skilled nursing facilities, home health agencies, and hospice services. They also process outpatient hospital claims for SMI. Examples of intermediaries are Blue Cross Blue Shield (which utilize their plans in various states) and other commercial insurance companies. Intermediaries' responsibilities include the following:

- Determining costs and reimbursement amounts
- Maintaining records
- Establishing controls
- Safeguarding against fraud and abuse or excess use
- Conducting reviews and audits
- Making payments to providers for services
- Assisting both providers and beneficiaries as needed

Medicare carriers handle SMI claims for services by physicians and medical suppliers. Examples of carriers are the Blue Cross or Blue Shield plans in a state, and various commercial insurance companies. Carriers' responsibilities include the following:

- Determining charges allowed by Medicare
- Maintaining quality-of-performance records
- Assisting in fraud and abuse investigations
- Assisting both suppliers and beneficiaries as needed
- Making payments to physicians and suppliers for services that are covered under SMI

Quality Improvement Organizations

Under the direction of the Centers for Medicare & Medicaid Services (CMS), the Quality Improvement Organization (QIO) Program consists of a national network of fifty-three QIOs responsible for each U.S. state, territory, and the District of Columbia. QIOs work with consumers, physicians, hospitals, and other caregivers to refine care delivery systems to make sure patients get the right care at the right time, particularly among underserved populations. The program also safeguards the integrity of the Medicare trust fund by ensuring payment is made only for medically necessary services, and investigates beneficiary complaints about quality of care. The ongoing effort to combat monetary fraud and abuse in the Medicare Program was intensified after enactment of the Health Insurance Portability and Accountability Act of 1996, which created the Medicare Integrity Program. Prior to this 1996 legislation, CMS was limited by law to contracting with its current carriers and fiscal intermediaries to perform payment safeguard activities. The Medicare Integrity Program provided CMS with stable, increasing funding for payment safeguard activities, as well as, new authorities to contract with entities to perform specific payment safeguard functions.

Medicaid

Title XIX of the Social Security Act is a Federal/State entitlement program that pays for medical assistance for certain individuals and families with low incomes and resources. This program, known as Medicaid, became law in 1965 as a cooperative venture jointly funded by the Federal and State governments (including the District of Columbia and the Territories) to assist states in furnishing medical assistance to eligible needy persons. Medicaid is the largest source of funding for medical and health-related services for America's poorest people.

Within broad national guidelines established by Federal statutes, regulations, and policies, each state:

1. Establishes its own eligibility standards
2. Determines the type, amount, duration, and scope of services
3. Sets the rate of payment for services
4. Administers its own program

Medicaid policies for eligibility, services, and payment are complex and vary considerably, even among states of similar size or geographic proximity. Thus, a person who is eligible for Medicaid in one state may not be eligible in another state, and the services provided by one state may differ considerably in amount, duration, or scope from services provided in a similar or neighboring state. In addition, state legislatures may change Medicaid eligibility and/or services during the year.

The Medicare-Medicaid Relationship

Medicare beneficiaries who have low incomes and limited resources may also receive help from the Medicaid Program. For such persons who are eligible for full Medicaid coverage, the Medicare

healthcare coverage is supplemented by services that are available under their State's Medicaid Program, according to eligibility category. These additional services may include, for example, nursing facility care beyond the 100-day limit covered by Medicare, prescription drugs, eyeglasses, and hearing aids. For persons enrolled in both programs, any services that are covered by Medicare are paid for by the Medicare Program before any payments are made by the Medicaid Program, since Medicaid is always the "payer of last resort."

Certain other Medicare beneficiaries may receive help with Medicare premium and cost-sharing payments through their State Medicaid Program. Qualified Medicare Beneficiaries (QMBs) and Specified Low-Income Medicare Beneficiaries (SLMBs) are the best-known categories and the largest in numbers. QMBs are those Medicare beneficiaries who have resources at or below twice the standard allowed under the SSI Program, and incomes at or below 100 percent of the Federal Poverty Level (FPL). For QMBs, Medicaid pays the Hospital Insurance (HI) and Supplemental Medical Insurance (SMI) premiums and the Medicare coinsurance and deductibles, subject to limits that States may impose on payment rates. SLMBs are Medicare beneficiaries with resources like the QMBs, but with incomes that are higher, though still less than 120 percent of the FPL. For SLMBs, the Medicaid Program pays only the SMI premiums.

A third category of Medicare beneficiaries who may receive help consists of disabled and working individuals. According to the Medicare law, disabled-and-working individuals who previously qualified for Medicare because of disability, but who lost entitlement because of their return to work (despite the disability), are allowed to purchase Medicare HI and SMI coverage. If these persons have incomes below 200 percent of the FPL but do not meet any other Medicaid assistance category, they may qualify to have Medicaid pay their HI premiums as Qualified Disabled and Working Individuals (QDWIs). According to CMS estimates, Medicaid currently provides some level of supplemental health coverage for 5 million Medicare beneficiaries within the above three categories.

For Medicare beneficiaries with incomes that are above 120 percent and less than 175 percent of the FPL, the BBA establishes a capped allocation to States, for each of the 5 years beginning January 1998, for payment of all or some of the Medicare SMI premiums. These beneficiaries are known as Qualifying Individuals (QIs). Unlike QMBs and SLMBs, who may be eligible for other Medicaid benefits in addition to their QMB/SLMB benefits, the QIs cannot be otherwise eligible for medical assistance under a State plan. The payment of this QI benefit is 100 percent federally funded, up to the State's allocation.

Chapter 1 - OVERVIEW OF MEDICARE

This chapter introduces the Medicare Program, which consists of two parts: hospital insurance, known as Part A and medical insurance known as Part B. A new third part of Medicare, sometimes referred to as Part C, is the Medicare + Choice Program. This program was established by the Balanced Budget Act of 1997 (BBA) and expanded beneficiaries' options for participation in private-sector healthcare plans. This chapter also discusses the ways that various federal organizations affect Medicare policies.

The following resources are available to beneficiaries and physicians who need information regarding Medicare:

Beneficiary

- Call 1-800-MEDICARE (1-800-633-4227) or TTY users should call 1-877-486-2048
- Go to www.medicare.gov on the Internet and click on publications to read or print various Medicare booklets including the *Medicare & You* handbook. Also available is information on how to contact local State Health Insurance Assistance Programs.

Physician

- Go to www.cms.hhs.gov/medlearn/tollnums.asp on the Internet to access phone numbers which will help you obtain answers to specific physician/supplier questions

Overview

What is Medicare?

Medicare is a federal health insurance program that provides medical coverage for people 65 or older, certain disabled individuals, and individuals with End-Stage Renal Disease (ESRD). The program, established by Congress through Title XVIII of the Social Security Act, began July 1, 1966. The U.S. Department of Health and Human Services (DHHS), through the Centers for Medicare & Medicaid Services (CMS), manages Medicare.

CMS provides operational direction and policy guidance for nationwide administration of the program, and it awards contracts to organizations called *contractors* to perform Medicare claims processing and related administrative functions.

Medicare Part A

Medicare Part A is Hospital Insurance. Fiscal intermediaries (FI) are contractors that administer Medicare Part A. This coverage helps to pay for (but is not limited to):

- Inpatient hospital care
- Inpatient care in a skilled nursing facility following a covered hospital stay
- Some home healthcare
- Hospice care

Part A is financed by:

- Payroll taxes paid by employers and employees, through the Federal Insurance Contributions Act (FICA)

- Self-employed individual contributions, through the Self-Employment Contributions Act
- Railroad workers and their employers and representatives, through the Railroad Retirement Act

Medicare Part B

Medicare Part B is Medical Insurance. Carriers are contractors that administer Medicare Part B. This coverage helps to pay for (but is not limited to):

- Medically necessary services provided by a physician. These services may be furnished in a variety of medical settings including, but not limited to, the physician's office, an inpatient or outpatient hospital setting, rural health clinics, and ambulatory surgical centers.
- Home healthcare
- Ambulance services
- Clinical laboratory and diagnostic services
- Surgical supplies
- Durable medical equipment and supplies
- Services provided by practitioners with limited licensing, such as:
 - Advanced Registered Nurse Practitioners (ARNPs)
 - Independently practicing physical/occupational therapists
 - Certified Registered Nurse Anesthetists (CRNAs)
 - Licensed Clinical Social Workers (LCSWs)
 - Audiologists
 - Nurse midwives
 - Clinical psychologists
 - Physician's Assistants (PAs)

Part B is financed by:

- Premium payments by enrollees
- Contributions from general revenues by the federal government
- Interest earned on the Part B "trust fund"

Medicare Part C

Medicare Part C or Medicare + Choice is a set of healthcare options created by the BBA to give Medicare beneficiaries more choices in healthcare and contractors. A Medicare beneficiary may choose to have covered items and services furnished to him or her through another plan, rather than traditional Medicare. Medicare + Choice plans include:

- Health Maintenance Organization (HMO)
- Point of Service option (POS)
- Provider Sponsored Organization (PSO)
- Preferred Provider Organization (PPO)
- Private fee-for-service plan (PFFS)
- Religious fraternal benefit society plan (RFB)

To participate in the Medicare Program, a Medicare managed care plan must have a contract with the Secretary of DHHS. It must provide the same services a beneficiary would be eligible to receive from Medicare if he or she were not a managed care plan enrollee. In other words, the beneficiary still technically “has Medicare” but has selected a different contractor and is required to receive services according to that contractor’s arrangements.

The beneficiary’s entitlement to Medicare is based on the same criteria, whether healthcare expenses are payable by an HMO or traditional Medicare carriers and/or fiscal intermediaries.

The four types of election periods in which Medicare beneficiaries may enroll or disenroll from a Medicare managed care plan are as follows:

- The annual election period, which occurs November 15 through December 31 each year.
- The initial coverage election period, which begins three months immediately before entitlement to Medicare Part A or enrollment in Part B and ends three months after entitlement.
- The special election period, (granted in certain situations) to allow beneficiaries to change Medicare + Choice plans or to return to Original Medicare.
- The open enrollment period, which runs from January 1 through December 31 of each year through 2004, if the health plan is open and accepting new members.

Medicare Eligibility

Hospital insurance (as well as medical insurance) is available to three basic groups of insured individuals:

- The aged
- The disabled
- Those with end stage renal disease

To be eligible for premium-free hospital insurance (Part A), an individual must be insured based on his/her own earnings or those of a spouse, parent, or child. To be insured, the worker must have a specified number of quarters of coverage (QCs), the exact number required is dependent upon whether the person is filing for Part A on the basis of age, disability or end stage renal disease. QCs are earned payment of payroll taxes under FICA.

Individuals, age 65 or older, who do not meet the insured status requirements for premium-free Part A may enroll in Part A on a premium paying basis if they are entitled to medical insurance (Part B) or are enrolling in Part B.

Medical insurance (Part B) is a voluntary program for which the enrollee pays a monthly premium. All individuals who are entitled to premium-free Part A are eligible to enroll in Part B. Individuals who are not eligible for premium-free Part A can enroll in Part B if they are: age 65, a resident of the U.S., and a U.S. citizen or a permanent alien resident.

Getting to Know Medicare Beneficiaries

Aged Insured

An “aged insured” is at least 65 years old and eligible for Social Security, Railroad Retirement, or equivalent Federal benefits.

Individuals with questions about Medicare eligibility and enrollment should be referred to their local Social Security District Office or the 1-800-MEDICARE Helpline.

Medicare Part A, hospital insurance, is effective the month the individual attains age 65, if he or she applies for the benefit within six months of his or her birth month. The rules governing the program

state that age 65 is attained the day before the 65th birthday. For example, an individual born on December 1 attains age 65 on November 30. Therefore, Medicare Part A would be effective November 1, if all other eligibility criteria have been met. Entitlement generally does not end until death.

Medicare Part B, medical insurance, is voluntary, and becomes effective when the individual enrolls and begins to pay the monthly premium. The earliest an individual may enroll in Part B is the first month of his/her initial enrollment period. The initial enrollment period is a seven-month period that begins the month a person turns age 65 and ends 7 months later. If a beneficiary enrolls during the last four months of his/her initial enrollment period, the Part B effective date will be delayed. If a beneficiary chooses not to enroll in Medicare Part B during the initial enrollment period, he or she may only enroll during other specified times.

An individual's coverage to premium-free Medicare Part A generally ends upon his or her death.

An individual's coverage to Medicare premium Part A may be terminated whenever any of the following occurs:

- A voluntary request
- Nonpayment of premium
- End of entitlement to Medicare Part B
- Death of the beneficiary

An individual's coverage to Medicare Part B may be terminated whenever any of the following occurs:

- A voluntary request
- Nonpayment of premium
- Termination of Medicare Part A benefits
- Death of the beneficiary

Disabled Insured

An insured entitled to Social Security, Railroad Retirement, or equivalent federal benefits, based on disability, is automatically entitled to Medicare Part A hospital insurance and enrolled for Medicare Part B medical insurance unless coverage is refused. Generally, entitlement begins after the individual has received disability benefits for 24 months, not the date he or she became disabled. Beginning July 1, 2001, individuals whose disability is Amyotrophic Lateral Sclerosis no longer have to wait 24 months for Medicare. These beneficiaries are entitled to Medicare effective the first month they are entitled to disability benefits. This type of entitlement is also available to a disabled widow, or widower, or the disabled child of a deceased, disabled, or retired worker.

If an individual recovering from a disability is not dually eligible for Medicare, entitlement ends the month following the month that notice of the disability termination is mailed. Medicare Part B entitlement based on disability also terminates for any situation listed above for Medicare Part B terminations for aged insured individuals.

End-Stage Renal Disease (ESRD) Insured

Individuals of any age who receive regular dialysis treatments or a kidney transplant are eligible for Medicare if they:

- Meet certain work requirements for Social Security insured status or are entitled to monthly Social Security benefits, or

- Are eligible under Railroad Retirement Programs or entitled to an annuity under the Railroad Retirement Act, or
- Are the spouses or dependent children of such insured or entitled persons.

Entitlement to Medicare usually begins after a three-month waiting period (e.g., with the first day of the third month after the month in which a course of renal dialysis begins). Entitlement can begin at an earlier date, if certain requirements are met.

Medicare is the secondary payer for claims for 30 months for ESRD beneficiaries who are covered by a group health plan (GHP). The exception is an aged or disabled beneficiary who had GHP coverage that was secondary to Medicare when ESRD occurred. This 30-month coordination period begins with the first day of Medicare eligibility.

Note: The BBA extended the ESRD coordination period from 18 months to 30 months for any individual whose coordination period began on or after March 1, 1996.

For patients eligible to Medicare solely based on ESRD, coverage ends on the earliest of the following dates:

- The patient's date of death
- The last day of the 12th month after the month the course of dialysis is discontinued, unless the patient receives a kidney transplant during that period or begins another course of dialysis.
- The last day of the 36th month after the month a person receives a kidney transplant. If the transplant fails and a regular course of dialysis is initiated or another transplant is performed within the 36 months, entitlement continues. If a patient whose entitlement based on ESRD has ended begins a new course of dialysis or has a kidney transplant, re-entitlement begins without a waiting period.

Medicare entitlement based on ESRD also terminates if any of the situations listed for Medicare Part B terminations under "Aged Insured."

Generally, an individual is not eligible to elect a Medicare + Choice plan if he or she is medically determined to have ESRD. There are exceptions to this eligibility rule, such as individuals who are already members of a Medicare + Choice plan when they develop ESRD and those individuals who received a kidney transplant and no longer require a regular course of dialysis treatments.

Medicare Beneficiary Rights

The guaranteed rights of Medicare beneficiaries includes:

- Protection when they get healthcare services
- Assured access to needed healthcare services
- Protection against unethical practices
- The right to receive emergency care without prior approval
- The right to appeal the Original Medicare Plan's decision about payment/services provided
- The right to information about all treatment options
- The right to know how their Medicare health plan pays its doctors
- The BBA (§4311) also gives beneficiaries the right to submit a written request to a physician or supplier for an itemized statement for any Medicare item or service received. The physician or supplier must furnish the itemized statement within 30 days of the request. Failure to provide the statement on time can result in a civil monetary penalty of up to \$100.00 for each occurrence.

Identification of Medicare Beneficiaries

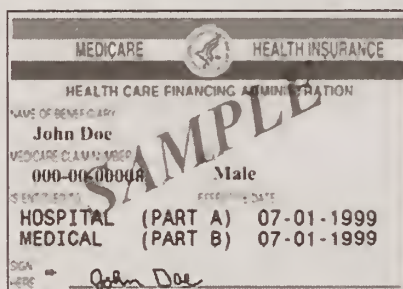
When an individual becomes entitled to Medicare, he or she receives a health insurance card. This card contains important information that must be included on all claims submitted by providers:

- Name
- Sex
- Health Insurance Claim (HIC) number
- Effective date of entitlement to hospital (Part A) insurance
- Effective date of entitlement to medical (Part B) insurance

Most Medicare beneficiaries receive health insurance cards issued by CMS; however, the Railroad Retirement Board (RRB) issues a Medicare card to individuals eligible for Medicare Railroad Retirement benefits.

CMS-Issued Medicare Cards

Medicare cards issued by CMS typically reflect the Social Security Number (SSN) of either the insured or a spouse (possible divorced or deceased) depending on the wage earner upon whose earnings eligibility is based. An added alpha or alphanumeric suffix denotes the category of eligibility including those who are required to pay monthly premiums for Part A coverage. Following is an illustration of a sample CMS Medicare identification card:



RRB-Issued Medicare Numbers

Medicare numbers issued by the RRB may be the insured's SSN or a six-digit number (zeros may be added at the beginning to bring it to nine digits). Regardless of the length of the number, the insured's number will always have an alpha prefix (with one or more characters). For example, H000-000 or H000-000-000 would be a railroad pensioner (by age or disability).

Verifying Beneficiary Eligibility

Eligibility for Social Security benefits is the basis for Medicare eligibility for most patients. The eligibility source can be determined by asking to see the patient's Medicare card. Maintaining a photocopy of the card in the patient's file may prevent errors. Failure to record on a claim the beneficiary's name and identification number exactly as they appear on the Medicare card may result in a payment denial or claim delay. The physician's office should develop a process to regularly verify Medicare insurance information and update patient records to reflect current information.

Note: Due to an increase in lost and stolen Medicare cards, verifying and copying a patient's picture identification is suggested to ensure the patient is eligible to receive benefits. If Medicare pays a claim for services rendered to a non-Medicare-eligible beneficiary, a refund request may be generated.

Claim Submission

Medicaid

Medicaid is a joint federal/state healthcare plan for beneficiaries who are financially unable to obtain health insurance. For physicians who accept Medicaid assignment, the Medicare and Medicaid payments represent payment in full for services rendered. In cases based on program limitations, Medicaid does not pay for specific services. Therefore, physicians should follow Medicaid collection guidelines.

A Medicaid beneficiary receives a Medical Identification Card (MIC) and an Authorization for Medical Eligibility (Form HRS-ES 2014) or an HMO/PHP card. If he or she is eligible for Medicare and Medicaid, the physician submits the claim to Medicare on an “assigned” basis (assigned claims are discussed in Chapter 3). Additionally, the patient’s Medicaid identification number is entered in block 10d (or the equivalent field on the electronic claim) of Form CMS-1500.

Note: Medicaid assigns each physician a unique provider number (separate from the Medicare provider number) for billing purposes. Physicians may contact the local Medicaid office for information about becoming a Medicaid provider.

Private Contracting with Medicare Beneficiaries

Certain physicians and practitioners (under a limited definition for this purpose) privately contract with Medicare beneficiaries. Please refer to Chapter 11, Private Contracting with Medicare Beneficiaries, for more information.

Durable Medical Equipment Regional Carrier (DMERC)

Physicians are required to submit most claims for durable medical equipment, prosthetics, orthotics, and supplies to one of the four Durable Medical Equipment Regional Carriers (DMERCs) that process DME claims. A listing of DMERCs is also available at www.cms.hhs.gov/contacts/incardir.asp on the Internet.

For a complete list of procedure codes billable to the DMERC, physicians may write to the local Medicare contractor or local DMERC.

Regional Home Health Intermediary (RHHI)

RHHIs currently process Part A hospice and home healthcare claims. The beneficiary’s home state determines which RHHI is responsible for processing his or her claim. For the appropriate State intermediary, physicians should contact their contractor. This information is also available at www.cms.hhs.gov/contacts/incardir.asp on the Internet.

Railroad Retirement Beneficiaries

Please refer to the earlier topic in this chapter, “Identification of Medicare Beneficiaries,” for more information. The local Medicare contractor can provide information on where to send claims for Railroad Retirement beneficiaries.

United Mine Workers of America (UMWA)

Some Medicare beneficiaries are members of the United Mine Workers of America (UMWA). The UMWA Health and Retirement Fund is a health benefit plan for retired UMWA coal miners, spouses, and dependents. The local Medicare contractor can provide information on where to send UMWA claims.

Medicare Managed Care Plan

When a beneficiary is a member of a Medicare managed care plan, the plan is responsible for paying claims under the following conditions:

- The physician is affiliated with the Medicare managed care plan
- The physician provides emergency services, urgently needed services, or other covered services not *reasonably available* through the Medicare managed care plan

When a physician submits claims for a beneficiary enrolled in a Medicare managed care plan, the local Medicare Part B carrier will deny payment (except dialysis and related services provided in a dialysis facility).

Receiving Reimbursement When Medicare Managed Care Plan Doesn't Pay

Physicians who do not have a contract with a Medicare managed care plan to provide services, yet provides services to an enrollee, should bill the enrollee's Medicare managed care plan. The physician can expect to receive what the physician would otherwise expect to receive under Medicare fee-for-service. However, if the claim or service is denied by the Medicare managed care plan, the physician should not bill the Medicare enrollee for any amount other than the cost-sharing amount(s) that the beneficiary would expect to pay as a member of a Medicare managed care plan. Medicare + Choice program requirements prohibit non-contracting providers from pursuing Medicare beneficiaries for payment of claims that are the legal obligation of a Medicare + Choice organization.

Physicians Who Are Not Medicare Managed Care Plan Providers

Before rendering service, physicians who are not Medicare managed care plan providers should emphasize to their Medicare managed care plan patients what their financial liability will be. If patients choose to see a non-Medicare managed care plan provider for healthcare services, they should clearly understand that they might be responsible for the full fee for services rendered.

Organizations That Affect Medicare

Federal Government

Congress passes laws that affect Medicare reimbursement of physicians and beneficiaries. Several congressional committees deal with Medicare legislation, including:

House of Representatives

- Ways and Means Committee
- Appropriations Committee
- Energy and Commerce Committee

Senate

- Appropriations Committee
- Finance Committee
- Energy and Commerce Committee

The Commerce Clearing House Guide to Medicare and Medicaid describes proposed legislative changes to the Medicare Program. For purchasing information, contact the Commerce Clearing House at www.cch.com on the Internet, by phone at 1-800-835-5224, or by writing to the following address:

Commerce Clearing House, Inc.
4025 West Peterson Ave.
Chicago, IL 60646-6085

Social Security Administration (SSA)

The SSA, an independent agency, has special responsibilities in five major benefit areas: retirement, disability, family benefits, survivors, and Medicare. SSA assures that beneficiaries are eligible for Medicare benefits and enrolls them in Parts A and/or B, Black Lung (the Funds Program), or Medicare + Choice. When a patient enrolls in Medicare, SSA issues an enrollment package and a Medicare identification card.

SSA is also responsible for:

- Maintaining deductible status
- Replacing lost or stolen Medicare cards
- Address changes
- Maintaining and establishing beneficiary enrollment
- Collecting premiums from beneficiaries
- Educating beneficiaries regarding coverage and insurance choices

Department of Health and Human Services (DHHS)

DHHS is the United States cabinet-level department that oversees federal health programs, including Medicare, and provides essential human services. The Secretary of DHHS contracts with private insurance companies to process Medicare claims. DHHS is responsible for conducting fraud and abuse audits and investigations for the federal government.

Centers for Medicare & Medicaid Services (CMS)

CMS is an agency of DHHS. It administers Medicare, Medicaid, and the State Children's Health Insurance Program by creating carrier and intermediary policy according to congressional mandates. CMS also regulates laboratory testing and surveys and certifies healthcare facilities, including nursing homes, home health agencies, intermediate care facilities for the mentally retarded, and hospitals.

The CMS central office is in Baltimore, Maryland; it provides operational direction and policy guidance for the nationwide administration of the Medicare and Medicaid Programs. Each regional office in Atlanta, Boston, Chicago, Dallas, Denver, Kansas City, New York, Philadelphia, San Francisco, and Seattle provides policy guidance to several Medicare contractors.

Office of the Inspector General (OIG)

The OIG, a DHHS organization, helps to protect Medicare by investigating suspected fraud or abuse and developing cases. It audits and inspects CMS programs and may act against individual healthcare providers through civil monetary penalties and exclusions, such as the exclusion of providers convicted of healthcare related offenses. When appropriate, OIG has the authority to refer cases to the U.S. Department of Justice for criminal or civil action.

State Government

A state agency (usually a health department component) surveys all Part A and certain Part B providers and suppliers and recommends to the Secretary of DHHS whether they are eligible to participate in the Medicare Program. The state agency's principal activities in this area include:

- Identifying an institution or facility that might qualify as a provider or supplier for the Medicare Program, using guidelines provided by the Secretary

- Inspecting, certifying, and recommending to the Secretary whether the provider or supplier qualifies as a participating provider or supplier
- Consulting with providers and suppliers to help them sustain quality standards compliance

State agencies are responsible for medical licensing of physicians. Physicians may contact provider associations or local governments for a list of state agencies to contact for various specialties.

State, county, and city agencies are also responsible for issuing applicable business licenses, based on jurisdictional law. Physicians should contact their state, county, and/or city for a list of appropriate agencies to contact regarding required business licenses.

Quality Improvement Organizations (QIO)

CMS administers the Quality Improvement Organization (QIO) Program, which is designed to monitor and improve utilization and quality of care for Medicare beneficiaries. The program consists of a national network of fifty-three QIOs (formerly known as Peer Review Organizations) responsible for each State, territory, and the District of Columbia. Each QIO maintains a staff of highly qualified, multi-disciplinary experts in medicine, quality improvement, health information management, statistical analysis, computer programming and operations, communications, public relations, and clerical/administrative support. Their mission is to ensure the quality, effectiveness, efficiency, and economy of healthcare services provided to Medicare beneficiaries.

QIOs are required to review all written quality of service complaints submitted by Medicare beneficiaries or their designated representatives. The review addresses whether the services met professionally recognized standards of healthcare and may include whether the appropriate services were or were not provided in appropriate settings. The QIOs' professional medical staff performs these reviews. The results of the reviews are submitted to CMS.

Chapter 2 - BECOMING A MEDICARE PHYSICIAN

This chapter discusses Medicare physicians and their reimbursement for services rendered, including how a physician becomes a Medicare provider, assignment of claims, the benefits of the Medicare Part B Participation Program, how reimbursement is calculated, payment incentives, and how limiting charges affect a nonparticipating physician's practice.

Medicare Part B Physicians

Physicians

The Medicare Program defines a *physician* as a doctor of medicine or osteopathy; a doctor of dental surgery or dental medicine; a chiropractor; a doctor of podiatry or surgical chiropody; or a doctor of optometry, legally authorized to practice by a state in which he or she performs this function. The services performed by a physician within these definitions are subject to any limitations imposed by the state on the scope of practice.

The issuance by a state for a license to practice medicine constitutes legal authorization. Temporary state licenses also constitute legal authorization to practice medicine. If state law authorizes local political subdivisions to establish higher standards for medical practitioners than those set by the state licensing board, the local standards are used in determining whether a particular physician has legal authorization. If the state licensing law limits the scope of practice of a particular type of medical practitioner, only the services within these limitations are covered.

Residents and Interns

For Medicare purposes, the terms interns and residents include physicians participating in approved Graduate Medical Education (GME) training programs and those who are not in approved programs but who are authorized to practice only in a hospital setting. These include, for example, individuals with temporary or restricted licenses and graduates of foreign medical schools who do not have a valid medical license. Receiving a staff or faculty appointment or participating in a fellowship does not alter the status of "resident" for the purposes of Medicare coverage and reimbursement.

Generally, the intermediary pays services of interns and residents as physician services. Except for services furnished by interns and residents outside the scope of their training program, the following types of services performed by interns and residents are reimbursable to the hospital under Part B on a reasonable cost basis:

- Services by interns and residents not in approved training programs
- Services performed for hospital outpatients
- Services generally covered under Part A, but for which the patient is not eligible under Part A (e.g., all inpatient hospital benefit eligibility has been used)

Intern and Resident Services Furnished Under an Approved Training Program

Medical and surgical services furnished by interns and residents within the scope of their training program are covered as physician services. This includes services furnished in a setting that is not part of the nonphysician facility when a hospital has agreed to incur all or substantially all the costs of training in the nonphysician facility. The physician is required to notify the Medicare carrier of such agreements. When a licensed physician performs the services, but the physician incurs little or none of the training costs, the carrier may reimburse the services on a reasonable charge basis.

Intern and Resident Services Furnished Outside an Approved Training Program

Medicare reimburses resident and intern medical and surgical services that are not related to the intern or resident training program if the services are performed in a hospital outpatient department or emergency room. The services may be covered as physician services, reimbursable on a reasonable charge basis, where the following criteria are met:

- Services are identifiable physician services that require performance by a physician in person and contribute to the diagnosis or treatment of the patient's condition
- Intern or resident is fully licensed as a physician for purposes of performing the services
- Services are performed under the terms of a written contract or agreement and can be separately identified from services required as part of the training program

When these criteria are met, the services are considered to have been furnished by the individuals in their capacity as physicians and not in their capacity as interns and residents. The Medicare carrier is expected to review the contracts/agreements for such services to ensure compliance with the above criteria.

Nonphysician Practitioners

Medicare allows payment for services furnished by nonphysician practitioners. These include but are not limited to: Advanced Registered Nurse Practitioners (ARNP), Clinical Nurse Specialists (CNS), Licensed Clinical Social Workers (LCSW), and Physician Assistants (PA).

To submit claims to Medicare for reimbursement, a nonphysician practitioner must first apply to the program by completing Form CMS-855I and submitting the required documentation. If the application is approved, payment is allowed for the practitioner's services in all areas and settings permitted under applicable state licensure laws.

Note: No separate payment may be made to the nonphysician practitioner if a facility or other physician payment is also made for such professional service.

When an ARNP or PA renders services that are integral, although incidental, to a physician's service, the physician's provider number should be submitted on the claim. In this situation, a provider number for the ARNP or PA is not needed. Please refer to Chapter 5, "Incident to" Provision, for more information.

Physicians/Suppliers

Medicare processes claims for certain physicians/suppliers (e.g., physician, nonphysician practitioner, independent diagnostic testing facilities, ambulance providers, portable X-ray units, and pharmacies). To submit claims to Medicare for reimbursement, providers/suppliers must apply to the program by completing Form CMS-855I and/or CMS-855B along with the required supporting documentation. If the application is approved, Medicare will notify the provider/supplier by issuing an identification number.

Note: Durable Medical Equipment (DME) suppliers should submit Form CMS-855S to the National Supplier Clearinghouse at: P.O. Box 100142, Columbia, SC 29202-3142. Claims for supplies, orthotics, prosthetics, equipment, and certain injectables are submitted to the Durable Medical Equipment Regional Carrier (DMERC). The beneficiary's home state determines which DMERC is responsible for processing his or her claim. For the appropriate DMERC, providers should contact their local carrier. This information is also available at www.cms.hhs.gov/contacts/incardir.asp on the Internet.

Medicare Part B Physician Enrollment

Physicians wishing to receive payment for Medicare services must complete the appropriate Form CMS-855, provider/supplier enrollment application. This form requests payment and other general information and documentation to ensure that an applicant is qualified and eligible to enroll in the Medicare Program.

The completed Form CMS-855I and documentation are sent to the local carrier's provider enrollment department. The carrier verifies the information and documentation and notifies the applicant of the decision. Notification includes the physician's provider identification number (PIN) for Medicare billing, which is used in all communication with the local carrier. The enrollment application may be obtained from the local carrier. This information is also available at www.cms.hhs.gov/providers/enrollment on the Internet.

Physician/Supplier Specialties

Medicare Part B enrolls physicians/suppliers based on their credentials or specialties. Medicare recognizes many specialties. Physicians may have a primary and a sub-specialty. Since a physician's specialty may be used to determine peer utilization comparisons, physicians should notify the carrier of their practice's predominant specialty for annotation in Medicare records. No payment differential is applied to a service based on specialty.

Physician Identification

Physicians receive several different identifying numbers:

- Provider Identification Number (PIN) – used as a provider billing number to receive reimbursement
- Unique Physician/Practitioner Identification Number (UPIN) – used only when a service requires a referring or ordering physician; never used as a provider billing number

Provider Identification Number

The PIN is the individual provider number issued by the local Medicare carrier. It identifies who provided the beneficiary's service and allows the physician/supplier or patient to receive reimbursement for claims filed to the Medicare carrier. The PIN format is unique and varies from carrier to carrier. All Medicare claims filed to the carrier require a PIN; if a provider fails to show a PIN in the appropriate paper claim block or electronic claim field, an "unprocessable" claim denial will result.

Individual Healthcare Practitioners

Individual healthcare practitioners are physicians and nonphysician practitioners who render medical services to Medicare beneficiaries and submit claims for the services rendered. These practitioners must complete Form CMS-855I.

Those individual healthcare practitioners who bill the Medicare carrier directly for their services will be issued their own individual PIN. The address tied to the PIN is usually the physician's billing/mailling address, which may differ from his or her physical address where medical services are rendered. Many carriers can maintain two addresses in the provider address file. Medicare may verify a new provider's address by contacting the post office, by a personal visit, or by other means.

Physician-Directed Group/Clinic Practice

A physician-directed group/clinic may be a partnership, association, or corporation composed of physicians or nonphysician practitioners who wish to bill Medicare as a unit. The group must complete Form CMS-855B.

If a physician wishes to file claims as part of a group/clinic, the group/clinic must request a group/clinic PIN number for billing purposes. Each local carrier issues its own group/clinic PINs, so number formats will vary by carrier. The group/clinic PIN makes the group unique when filing services to the local carrier.

The address tied to the PIN is usually the group/clinic's billing or mailing address, which may differ from the physical address. Many carriers can maintain two addresses in the provider address file. Medicare may verify a new group's address by contacting the post office, by a personal visit, or by other means.

Reassignment of Benefits: Each member within the group/clinic must complete an Individual Reassignment of Benefits, Form CMS-855R, stating they agree to turn all monies over to the group/clinic. After the reassignment agreement has been signed, the local Medicare carrier will tie the individual physician's PIN to the group/clinic PIN. When the group/clinic bills Medicare, they must use this provider number when filing for services performed as part of the group.

New PIN, New Group Member, Change of Address

Providers/suppliers should contact the carrier with requests for the appropriate Form CMS-855 to apply for provider numbers, add new group members, or change addresses. This information is also available at www.cms.hhs.gov/providers/enrollment/forms on the Internet.

Unique Physician/Practitioner Identification Number (UPIN)

The UPIN is assigned by CMS. It is a six-character alphanumeric code identifying the Medicare provider. This number is assigned to physician, nonphysician practitioners, groups/clinics, and suppliers (excluding those billing to the DMERC) to identify the referring or ordering physician on the Medicare claim.

Each individual practitioner (physicians and nonphysician practitioners only) receives one UPIN, regardless of the number of practice settings. The individual practitioner keeps the UPIN throughout his or her Medicare affiliation, regardless of the state he or she practices in. CMS uses the UPIN to identify the ordering and referring physician, to aggregate payment and utilization information for individual practitioners, to ensure compliance with contractor recommendations for sanctions, and to validate duplicate services.

When a UPIN is Required

A UPIN is required if the service is requested by:

- A referring physician who requests an item or service for a beneficiary, for which payment may be made under the Medicare Program
- An ordering physician who orders nonphysician services for a beneficiary, such as diagnostic laboratory tests, clinical laboratory tests, or durable medical equipment

Services Requiring a UPIN

The UPIN requirement is based on the type of service, not the physician's specialty. Services currently include:

- Consultation services
- Routine foot care
- Durable medical equipment and other medical supplies
- Orthotics/prosthetic devices, including optical supplies

- Most diagnostic services, including laboratory and radiology services
- Services by independently practicing physical or occupational therapists

Entering the UPIN on a Claim

When filing Form CMS-1500, the referring/ordering physician's CMS-assigned UPIN must be entered in block 17a and the name of the referring physician in block 17. When filing electronically, the same information is required in the equivalent fields. Multiple referring and/or ordering physicians require a separate claim for each ordering/referring physician's service.

Ordering/Referring Physician Without a UPIN

A surrogate UPIN is used temporarily if a UPIN has been requested, but no UPIN has been assigned to the ordering/referring physician. A surrogate UPIN has three alpha characters followed by three zeros. All surrogate UPINs, except those of retired physicians (RET000) may be used only until an individual UPIN is assigned. Carriers monitor all surrogate UPINs for misuse. Surrogate UPINs require the physician's name and address. Ordering/referring physicians who may require a surrogate UPIN are:

- RES000 – intern, resident, and fellow
- VAD000 – physicians serving on active duty in the United States military and those employed by the Department of Veterans Affairs
- PHS000 – physicians in the Public Health Service, including the Indian Health Service
- RET000 – retired physician (Retired physicians who were assigned a UPIN must use their assigned UPIN)
- OTH000 – ordering/referring physicians who have not received a UPIN and do not meet the criteria for one of the other surrogate UPINs; used until an individual UPIN is assigned

If a Referring Physician Does Not Exist

When services requiring a UPIN are performed, and no referring physician exists, the UPIN and name of the *performing* physician are to be reported.

Participation Program

Participation in the Medicare Program means a physician voluntarily enters into an agreement to accept assignment for all services provided to Medicare patients and becomes a participating physician. Participating physicians and suppliers must accept assignment of Medicare benefits for all covered services for all patients. A nonparticipating physician (one who chooses not to participate) may accept assignment of Medicare claims on a case-by-case basis.

Deciding Whether to Participate

Physicians have only one opportunity each year to change their participation status for the following calendar year. This occurs during the carrier open enrollment period, usually in November.

Each active Medicare physician receives a participation package during the open enrollment period. This package normally contains information about:

- Advantages of participation
- Medicare physician fee schedule allowances for the next calendar year
- Proposed legislative changes that could impact the participation decision
- Physician's current participation status and year of practice for new physicians (if applicable)

- Form CMS 460 – Medicare Participating Physician or Supplier Agreement form which does not need to be completed or returned to Medicare if there is no change in participation status for the following year

Changing Participation Status

The participation period is one year (from January 1 to December 31). Once a physician signs a participation agreement, Medicare rarely honors a decision to change participation status during the year. However, a physician wishing to change participation status during the year must notify the local carrier's provider enrollment department and state the reason for the change. The carrier will then consider the request. A participating physician who wishes to continue participating need not sign another participation agreement. The current agreement will remain in effect until the physician notifies the carrier otherwise.

Benefits of Participation

Benefits of becoming a participating physician include the following:

- **Eligibility access:** Participating physicians submitting electronic claims may review beneficiary eligibility files via vendor access. Please refer to Chapter 3, Electronic Media Claims, for more information.
- **Financial:** Medicare fee schedule allowances are five percent higher for participating physicians. In addition, physicians who participate are not subject to limits on actual charges.
- **Medigap:** Claims with Medigap information will automatically crossover to the beneficiary's supplemental insurer. Please refer to the topic later in this chapter, Medigap, for more information.
- **MEDPARD Directory:** Contains a listing of all participating physicians. Carriers maintain a toll-free telephone line that allows Medicare beneficiaries to request information about local participating physicians. Some carriers maintain MEDPARD directories on their Web site.

The local carrier can provide physicians with information about the Participation Program.

The Nonparticipating Physician:

- Is held to a limiting charge when submitting nonassigned claims
- Must file all claims for potentially reimbursable services on behalf of his or her Medicare patients
- May collect up to the limiting charge at the time the services are rendered
- Is reimbursed a Medicare fee schedule allowance that is five percent lower than that of a participating physician

Reimbursement

Medicare Part A Reimbursement

Medicare Part A claim reimbursement is based on the provider's cost, as negotiated with the fiscal intermediary (FI). Reimbursement includes services provided by:

- Home health agencies
- Rural health clinics
- Hospitals

- Skilled nursing facilities
- Nursing homes

Part A inpatient hospital care is reimbursed at a predetermined rate per discharge, in accordance with the Diagnosis Related Group (DRG) and at a federally standardized payment amount that is payment in full for inpatient operating and capital costs. The provider may collect reimbursement from the beneficiary for excluded services, unmet deductible, and coinsurance amounts.

Medicare Part B Reimbursement

Medicare Part B claim reimbursement is based on an established “fee-for-service” schedule for services filed to the carrier. These services are:

- Physician services
- Clinical laboratory
- Injectables
- Durable Medical Equipment (DME)

Medicare Part B physicians are reimbursed at 80% of the lower of the established fee schedule, reasonable or customary charge (depending on the type of physician), or the billed charge for the following services:

- Physician services
- Ambulance
- DME
- Diagnostic tests

Some services are reimbursed at 100% of the lower of either the established fee schedule or their billed charge. These services are:

- Clinical laboratory
- Influenza or pneumococcal vaccinations
- Other exceptions as defined by CMS

Facility Fee Pricing Schedule

Services primarily performed in the following settings are subject to a payment limit:

- An inpatient or outpatient hospital setting
- A hospital emergency room
- A Skilled Nursing Facility (SNF)
- A comprehensive inpatient or outpatient rehabilitation facility
- An inpatient psychiatric facility
- An Ambulatory Surgical Center (ASC)

Medicare pays less because the physician’s overhead and other related expenses are lower than in the standard office setting. Physicians are not permitted to bill the beneficiary for the difference between the actual charges and the reduced allowed amount based on the location of the service.

Note: For the above situations, the allowed amount will be the lower of the actual charge or the reduced fee schedule amount. Carriers are required to publish facility fee pricing schedules.

The Medicare Part B Physician Fee Schedule

Physician services are paid through a fixed fee schedule, charges for which are based on three key Resource-Based Relative Value Units (RBRVUs). The RBRVU system fixes a national value for each procedure code, based on the sum of the RBRVUs associated with:

- The physician's time, intensity, and technical skill required to render a service
- The practice's overhead expenses, such as rent, office staff salaries, and office supplies
- Malpractice insurance premiums

RBRVUs are established locally to allow for variations in practice costs among geographic areas, and each pricing locality for a given state has a Geographic Practice Cost Index (GPCI) for each RBRVU.

Physician fee schedules for all Medicare Part B carriers are calculated using one national Conversion Factor (CF). Congress determines the CF each year, considering the projected inflation rate, projected vs. actual claims volumes, Medicare enrollment changes, and other factors potentially impacting the Medicare Part B budget.

Capitation Rate

A *capitation rate* is a fixed amount CMS pays a participating managed care plan that is selected by an enrolled Medicare beneficiary. CMS pays the plan, which then reimburses the physician for services provided within the terms of the agreement/plan, regardless of the cost or amount of care provided to each Medicare beneficiary enrolled in the managed care plan.

Physician Collection from Patients

On *assigned* claims, the Medicare beneficiary is responsible for:

- Unmet deductibles
- Excluded services
- Applicable coinsurance amounts

On *nonassigned* claims, the Medicare beneficiary is responsible for the entire bill up to, but not exceeding, the limiting charge for most services provided by a nonparticipating physician. Physicians may obtain current year fee schedule amounts, including limiting charge information from the local Medicare carrier.

Medicare Deductibles

Like most insurance plans, Medicare Parts A & B have *deductibles*, applicable to covered services and supplies, that must be satisfied before the carrier or intermediary pays.

Physicians must collect the unmet deductible from the beneficiary. Consistently waiving the deductible may be interpreted as *program abuse*. If a beneficiary is unable to pay the deductible, the physician should ask him or her to sign a waiver that explains the financial hardship. If no waiver is signed, the beneficiary's medical record should reflect *normal and reasonable* attempts to collect, before the charge is written off.

Medicare Coinsurance

Coinurance is the amount that Medicare will not pay; the beneficiary or the beneficiary's supplemental insurance company is responsible for paying coinsurance to the physician.

Coinurance amounts are generally 20% of the Medicare fee schedule. Physicians must collect the unmet coinsurance from the beneficiary. Consistently waiving the coinsurance may be interpreted as *program abuse*. If a beneficiary is unable to pay the coinsurance, the physician should ask him or her

to sign a waiver that explains the financial hardship. If no waiver is signed, the beneficiary's medical record should reflect *normal and reasonable* attempts to collect, before the charge is written off.

Note: *Normal and reasonable* means applying normal collection processes to Medicare as well as non-Medicare patients. For example, if a physician normally telephones non-Medicare patients and sends two written notices before writing off charges or referring them to a collection agency, Medicare patients must receive the same treatment.

Medicare Premium Amounts for 2003

The Medicare premium is the amount a beneficiary regularly pays to Medicare for healthcare coverage.

Part A (Hospital Insurance)

- Deductible: \$840.00 (per benefit period)
- Coinsurance: \$210.00 a day for days 61-90 each benefit period; \$420.00 a day for days 91-150 for each lifetime reserve day used (total of 60 lifetime nonrenewable reserve days)
- Premium: \$316.00 a month (This premium is paid only by individuals who are not otherwise eligible for premium-free hospital insurance and have less than 30 quarters of Medicare-covered employment.) The premium is \$174.00 for those individuals having 30-39 quarters of Medicare covered employment.
- Skilled Nursing Facility Coinsurance: \$105.00 a day for days 21-100 each benefit period

Part B (Medical Insurance):

- Deductible: \$100.00 per year (The beneficiary is responsible for 20% of the Medicare approved amount for services after the \$100.00 deductible is met.)
- Premium: \$58.70 a month

Note: Premium amounts for Medicare Parts A & B are available at www.medicare.gov on the Internet.

Supplemental Insurance

Supplemental insurance or coverage is a policy purchased by a beneficiary to help pay for expenses not paid by Medicare, such as deductibles, coinsurance, and excluded services.

Supplemental insurers may arrange for Medicare to file supplemental claims automatically. In cases where supplemental insurers do not have this arrangement with Medicare, beneficiaries must file their own supplemental claims. Traditional supplemental insurance policies directly reimburse patients who are in turn responsible for reimbursing the healthcare provider.

Exclusions include:

- Date(s) of service outside the patient's eligibility period
- Claims paid at 100 percent of Medicare approved amount
- Medicare claims containing totally denied services

Medigap

Medigap is privately offered Medicare supplemental health insurance specifically designed to supplement Medicare benefits.

A Medigap plan is a health insurance plan that helps bridge gaps in Medicare plan coverage. In all states, there are basic standardized Medigap plans. Each plan has a different set of benefits and pro-

vides payment for some expenses not paid by Medicare such as deductibles, coinsurance, or other limitations imposed by Medicare.

Under the Omnibus Budget Reconciliation Act of 1987 (OBRA 87) Medigap provision, a Medicare beneficiary with a Medigap policy may authorize the participating supplier of services to file a claim on his or her behalf and to receive payment directly from the Medigap insurer, instead of through the beneficiary. The Medicare carrier is required to “crossover” any Medicare claim for services rendered by a participating provider (physician or supplier) when the beneficiary has reassigned these benefits. The Medigap insurer is then required to pay any supplemental benefits directly to the provider. The reassignment of these benefits is made on a per claim basis and requires signed authorization from the beneficiary.

Medigap is an added benefit to the participating physician. This crossover process eliminates the need for the beneficiary or provider to file a separate claim to the beneficiary’s supplemental insurer. By submitting a single Medicare claim that includes accurate Medigap insurer policy information and the beneficiary’s signed authorization, the provider receives both the Medicare and coinsurance amounts.

The following guidelines apply when providers submit Medigap claims:

- Medigap policy information must be accurately reported on the Medicare claim
- The reassignment of supplemental Medigap benefits may be made only to participating Medicare providers
- The beneficiary must sign authorization for the reassignment of Medigap benefits
- Crossover occurs on a per claim basis

Financial Incentive

Medicare has a special financial incentive for additional reimbursement, to ensure that Medicare beneficiaries located in rural areas have healthcare access. This special incentive is available in Health Professional Shortage Areas located throughout the United States.

Medicare Part B Health Professional Shortage Area (HPSA)

A HPSA is an area of a state designated as a medically under-served area. A HPSA may cover an entire county or only a portion of a county or city and is designated as a rural or an urban HPSA. Census tracts define portions of counties eligible for incentive payments. Physicians should contact the local Medicare carrier to locate HPSAs in a particular state.

Incentive payment for services rendered in a HPSA is determined and issued on a quarterly basis for assigned and nonassigned claims for physician-designated services. The HPSA incentive payment is 10% of the amount Medicare paid to the physician in the previous quarter. A summary explanation accompanies each quarterly incentive check.

Physicians should indicate one of the following modifiers (two-digit alphanumeric code that affects reimbursement, used in conjunction with a procedure code) on the claim form to identify services rendered in a HPSA:

- *QB* - Physician service rendered in a rural HPSA
- *QU* - Physician service rendered in an urban HPSA

For the purpose of this provision of the law, only physician services are eligible for HPSA payments and are further defined as the following physician types: Medical Doctor (M.D.), Doctor of Osteopathy (D.O.), Doctor of Chiropractic Medicine (D.C.), Doctor of Podiatric Medicine (D.P.M.), Doctor of Dental Surgery (D.D.S.), and Doctor of Optometry (O.D.).

Limits on What Medicare Patients May Be Charged

The *limiting charge* represents the maximum amount that a *nonparticipating* physician may legally charge a Medicare beneficiary for services billed on *nonassigned* claims.

Such limits are not applicable to charges made by *participating* physicians, nor for any services billed on an *assigned* basis by *nonparticipating* physicians. Limiting charges are not used to determine the payment allowance, but are intended to minimize beneficiary liability on nonassigned claims.

Calculation of Limiting Charges

The limiting charge may be no higher than 15 percent above the fee schedule amount for nonparticipating physicians (e.g., 115 percent). The limiting charge may be rounded to the nearest dollar if done so consistently for all services. The following formula is used in rounding:

- \$.01 - \$.49 – round down
- \$.50 - \$.99 – round up

Fee Schedule Allowances

Fee schedule allowances of each procedure code for participating and nonparticipating physicians, including limiting charges for nonassigned claims, may be obtained from the local Medicare carrier.

Exceptions to Limiting Charge Rules

Generally, all services reimbursed under the physician's fee schedule are subject to the limiting charge. Some common exceptions are:

- Services that are never covered by Medicare
- Durable Medical Equipment (DME)
- Prosthetics/orthotics
- Technical components of diagnostic tests
- Portable X-ray services
- Independent laboratories
- Ambulance services
- Injectable drugs/biologicals

Notifying Beneficiaries of Limiting Charges

Beneficiaries receive an Explanation of Medicare Benefits (EOMB) or Medicare Summary Notice (MSN) for each service that is rendered. The EOMB or MSN:

- Notifies patients of their liability
- Alerts them to excess billed amounts that must be refunded to them

Medicare Part B Reimbursement of Physician Services

The following examples show how basic reimbursement by Medicare Part B is calculated, depending on a physician's participation status and whether or not assignment is accepted:

Participating Physician Must Always Accept Assignment

1. Submitted charge = \$125.00
2. Medicare allowed (participating fee schedule) amount = \$100.00
3. Medicare pays physician 80% = \$80.00
4. Patient is billed for 20% coinsurance = \$20.00

5. Physician may collect the 20% coinsurance amount from the patient = \$20.00

Nonparticipating Physician Who Does Not Accept Assignment

1. Submitted charge (Medicare limiting charge) = \$109.25
2. Medicare allowed (nonparticipating fee schedule) amount = \$95.00
3. Medicare pays patient 80% of fee schedule = \$76.00
4. Physician may collect from patient up to the limiting charge (\$109.25) = \$33.25

Note: This is the difference between the limiting charge (\$109.25) and 80% of Medicare's nonparticipating fee schedule allowed amount (\$76.00).

Nonparticipating Physician Who Accepts Assignment

1. Submitted charge = \$125.00
2. Medicare allowed (nonparticipating fee schedule) amount = \$95.00
3. Medicare pays physician 80% of fee schedule = \$76.00
4. Patient is billed for 20% coinsurance = \$19.00
5. Physician may collect the 20% coinsurance amount from the patient = \$19.00

Note: A physician may bill the beneficiary for all services that are *excluded* by Medicare, any unmet deductible, and the 20 percent coinsurance provided the claim is not subject to Medigap provisions for *assigned* claims.

Chapter 3 - CLAIMS AND FILING METHODS

This chapter introduces some of the various types of Medicare claims that may be filed. Specific electronic field claim requirements, as well as instructions for completion of Form CMS-1500, may be obtained from the local Medicare Part B carrier. Additionally, physicians may obtain these instructions from at www.cms.hhs.gov/providers/edi/edi5.asp on the CMS Web site.

Types of Claims

A claim or request for Medicare payment may be *assigned* or *nonassigned*. Regardless of the type of claim, physicians may never charge Medicare patients for completing or filing a claim. Proper completion and submission of a “clean” Medicare claim is the first step in accurate claims processing. Clean claims are claims that successfully process without system-generated requests for additional information.

Assigned Claims

A *participating* or *nonparticipating* physician may file an *assigned* claim. Participating physicians are required to accept assignment for all Medicare claims. A nonparticipating physician is held to the assignment agreement for that claim only and agrees to accept the Medicare fee schedule amount as payment in full for all covered services. The *physician* is reimbursed directly. To accept assignment of Medicare benefits for a claim, the physician must select the appropriate block (27) of Form CMS-1500 or the applicable electronic claim field. Physicians may collect reimbursement for excluded services, unmet deductible, and coinsurance, from the beneficiary.

Certain services may be paid *only* on an assigned basis:

- Clinical diagnostic laboratory services
- Physician services to individuals dually entitled to Medicare and Medicaid
- Services of physician assistants, advanced registered nurse practitioners, clinical nurse specialists, nurse midwives, certified registered nurse anesthetists, clinical psychologists, and clinical social workers
- Ambulatory Surgical Center (ASC) facility charges
- Home dialysis supplies and equipment paid under Method II
- All drugs and biologicals covered under Medicare

Nonassigned Claims

Only a *nonparticipating* Medicare physician may file *nonassigned*. A nonparticipating physician does not agree to accept Medicare’s allowed amount as payment in full and may charge the beneficiary, up to the limiting charge, for the service(s).

When a nonparticipating physician files a Part B nonassigned claim, the *beneficiary* is reimbursed directly. To refuse assignment of Medicare benefits for a claim, the physician must select the appropriate block (27) of Form CMS-1500 or the applicable electronic claim field.

How to Submit Claims

Claims may be filed to the Medicare Part B carrier in one of two ways:

- Electronic transmission from the physician’s office or from a billing service contracting with the physician

- Paper claim (Form CMS-1500) where not prohibited under the mandatory Medicare electronic filing requirements October 16, 2003 and later

Claims may be electronically submitted to Medicare from a physician's office using a computer with software that meets electronic filing requirements. A sender number is issued, and claims are transmitted directly from the physician's office, giving the physician control over timeliness and accuracy of claims. Medicare carriers offer free or low-cost billing software that allows electronic transmission directly to the Medicare carrier. Commercial software is also available that can be used to bill multiple health plans, including Medicare, as well as perform other practice management services. If the physician does not have a computer system meeting the requirements, a billing service may be used to submit claims. Either way, specific processing requirements—and benefits—are associated with filing claims electronically.

Electronic Data Interchange (EDI)

EDI, electronic submission of Medicare Part B claims eliminates mailroom processing and manual data entry. The Medicare claims processing system can usually pay electronic claims faster than paper claims. Generally, electronic claims can be paid on the 14th day after submissions, but paper claims cannot be paid earlier than the 27th day after submission.

EDI saves the physician time and money through more accurate, faster processing of claims and reduced postage costs. Physicians should contact the local Medicare carrier for information about EDI.

How EDI Works

The claim is electronically transmitted in data “packets” from the physician's computer modem to the carrier's modem over a telephone line. The carrier checks (“edits”) the data for required information. Claims that pass these initial edits, commonly known as *front-end edits* or *pre-edits*, are then processed according to Medicare policy and guidelines. Claims with inadequate or incorrect information do *not* pass the initial edits. They are rejected and *are not paid* because they lack sufficient information to make a payment decision.

After successful transmission, an *acknowledgement report* is generated and is either transmitted back to the physician or placed in an electronic mailbox for the physician to download. This report confirms that the file was received and lacks format errors. Once the claims are processed another report is generated that indicates the number of claims accepted and the total dollar amount transmitted. Additionally, this report lists claims that were rejected, as well as, the reason(s) for being rejected. The physician should review this report carefully. At this point, the physician can make necessary corrections to the rejected claim(s) and resubmit them.

Additional Information Requests

Occasionally, claims require additional information before they can be processed. A development letter, requesting the missing information, is sent to the physician and/or beneficiary. When the information is received, the claim is processed for payment consideration. Failure to respond to a request for additional development may result in denial of a physician's claim.

Certificates of Medical Necessity (CMN)

Physicians who submit claims electronically may also submit CMNs electronically along with the electronic claim. CMNs are used by the physician to electronically submit claims for services that require additional information, such as, ambulance, chiropractor, Durable Medical Equipment (DME), and oxygen services.

Note: The local carrier can provide additional information on when a CMN is required with the claim.

Additional EDI Benefits

In addition to the day-to-day benefits of electronic claims filing, other electronic transactions are also available:

- *Eligibility Query*: The physician can determine electronically if a patient is eligible for Medicare benefits, has met the Medicare deductible, or is enrolled in a Health Maintenance Organization.
- *Electronic Remittance Advice (ERA)*: Physicians can receive paid and/or denied claims information electronically from the Medicare Part B system. ERA may be used to automatically update physician accounts receivable files or the patient billing system. The ERA is the equivalent of the Medicare standard paper remittance (SPR) form.
- *Electronic Claims Status*: Physicians obtain a status report for each Medicare Part B pending claims.
- *Electronic Funds Transfer (EFT)*: With EFT, Medicare Part B can send payments directly to a physician's financial institution whether claims are filed through EMC or on paper. All registered Medicare providers may apply for EFT.

Advantages of Electronic Funds Transfer (EFT)

EFT is similar to other direct deposit operations such as paycheck deposits, and it offers a safe modern alternative to paper checks. Providers who use EFT may notice the following benefits:

- Reduction to the amount of paper in the office
- Valuable time savings for staff and avoidance of hassle associated with going to the bank to deposit Medicare checks
- Elimination of the risk of Medicare paper checks being lost or stolen in the mail
- Faster access to funds; many banks credit direct deposits faster than paper checks.

How to Enroll in EFT

All Medicare contractors include an EFT authorization form in the Medicare enrollment package. Complete the form and mail it to the Medicare contractor. Be sure to include a voided blank check so account information may be verified. If eligible, Medicare payments will be made directly to the financial institution through EFT, in as little as two weeks.

Note: Contact the Medicare contractor for additional qualifications and terms. If for some reason the form is not received with the enrollment package, simply contact the Medicare contractor and request a form.

Filing Form CMS-1500

Medicare Part B physicians may use the *red-printed* Form CMS-1500 to file various health insurance claims to private insurers and government programs. However, payment for paper claims takes substantially longer than payment for electronically submitted claims. Generally, electronic claims can be paid 14 days after submission, as opposed to paper claims that process in about four weeks.

How Paper Claim Submission Works

When filing paper claims, physicians must type or machine-print all mandated claim fields on the *red-printed* Form CMS-1500 and mail it to the local carrier. Some carriers may be able to accept a black and white copy of Form CMS-1500. Other carriers may not accept black and white copies of the form if they are using Optical Character Recognition (OCR) equipment to process the form.

Optical Character Recognition

Carriers that process claims with OCR, use an automated scanning process similar to scanners that read price labels in grocery stores. OCR claims processing is faster and more accurate than systems requiring manual input. However, to work properly, OCR must accurately read and interpret the characters entered in each field. It reads only typed or machine-printed data. Only an original, red and white Form CMS-1500 may be submitted. Black and white photocopies cannot be machine read and will be returned.

After claims information is scanned, it is transmitted to the claims processing system, where it is validated.

To ensure accurate, quick claim processing, the following guidelines must be followed:

- Do not staple, clip, or tape anything to Form CMS-1500
- Place all necessary documentation in the envelope with Form CMS-1500
- Put the patient's name and Medicare number on each piece of documentation submitted
- Use dark ink
- Use only upper-case (CAPITAL) letters
- Use 10 or 12 pitch (pica) characters and standard dot matrix fonts
- Do not mix character fonts on the same form
- Do not use italics or script
- Avoid using old or worn print bands or ribbons
- Do not use dollar signs, decimals, or punctuation
- Enter all information on the same horizontal plane within the designated field
- Do not print, hand-write, or stamp any extraneous data on the form
- Use only lift-off correction tape to make corrections
- Ensure data is in the appropriate field and does not overlap into other fields
- Remove pin-fed edges at side perforations
- Use only an original red-ink-on-white-paper Form CMS-1500

The Form CMS-1500 is available in various formats from the U.S. Government Printing Office (GPO). The GPO may also provide negatives of the form. For purchasing information, contact the GPO at <http://bookstore.gpo.gov> on the Internet, by phone at 1-866-512-1800, or by writing to the following address:

Superintendent of Documents
P.O. Box 371954
Pittsburgh, Pennsylvania 15250-7954

Remittance Notices

After Medicare processes a claim, a *remittance advice*, with final claim information, goes to the physician. Each service is shown with an explanation of Medicare allowances and payments as well as appropriate deductible or denial information. In addition to this notice, Medicare notifies the beneficiary with a Medicare Summary Notice, Explanation of Medicare Benefits, or Notice of Utilization.

The type of notification that the beneficiary receives depends on the carrier or intermediary processing the claim.

Unprocessable Claims

The term *return as unprocessable* refers to the Medicare process for notifying a physician that his or her claim cannot be processed, due to certain incomplete or incorrect information. Once the errors are corrected, the claim may be resubmitted and considered for payment. A physician is required to submit a Medicare claim for beneficiaries who have received services regardless of whether or not the physician accepts assignment. Therefore, a physician who has not accepted assignment on a claim is required to correct claims returned as unprocessable so that a determination can be made on the claim. Unlike denied claims, claims returned as unprocessable do not have appeal rights.

Chapter 4 - MEDICARE SECONDARY PAYER

Medicare secondary payer (MSP) refers to situations where the Medicare program does not have primary responsibility for paying a beneficiary's health care expenses, i.e., where the Medicare beneficiary has other health insurance or coverage that is required to pay primary health benefits.

Until 1980, the Medicare program was the primary payer in all situations except those involving Workers' Compensation (including Black Lung) benefits. Since 1980, changes in the Medicare law have resulted in Medicare being the secondary payer in other situations. The MSP Program protects Medicare funds and ensures that Medicare does not pay for services reimbursable under private insurance plans or other government programs. Medicare may not pay if payment has been made, or can be reasonably expected to be made, with respect to an item or service that is covered under other health insurance or coverage.

Medicare Coordination of Benefits (COB)

The Centers for Medicare & Medicaid Services (CMS) implemented a new initiative on January 8, 2001, to centralize Medicare's COB activities. This is one of many CMS initiatives designed to further expand the campaign against Medicare fraud, waste, and abuse under the Medicare Integrity Program (MIP). CMS awarded the COB contract to consolidate activities that support the collection, management, and reporting of other insurance coverage of Medicare beneficiaries.

The purpose of the COB Program is to identify health benefits available to a Medicare beneficiary and to coordinate the payment process to prevent the mistaken payment of Medicare benefits. Information regarding other payers is obtained from the Common Working File (CWF) and is used by Medicare carriers to facilitate accurate payment.

The Medicare COB Contractor (COBC) provides many benefits for employers, physicians, suppliers, third-party payers, attorneys, beneficiaries, and federal and state programs. All MSP claim investigations will be initiated and researched by the COBC, not by the local Medicare intermediary or carrier. This one-step approach greatly minimizes the amount of duplicate MSP investigations. It also offers a centralized one-stop customer service approach for all MSP-related inquiries, including those for general MSP information (but not related to specific claims or recoveries that serve to protect the Medicare trust fund). The COB contractor will provide customer service to all callers from any source, including, but not limited to beneficiaries, attorneys, or other beneficiary representatives, employers, insurers, physicians, and suppliers.

A variety of methods and programs are used by the COBC to identify situations in which Medicare beneficiaries have other health insurance that is primary to Medicare. Intermediaries and carriers continue to process claims submitted for primary or secondary payment. The processing of Medicare claims to adjudication is not a function of the COBC.

For all MSP inquiries, contact the COB contractor at: 1-800-999-1118 or TDD/TYY 1-800-318-8782. For claims-related and recovery questions, call your local intermediary and/or carrier.

Note: All possible insurers must be identified. There may be situations in which more than one insurer pays primary to Medicare (e.g., automobile insurer, group health plan [GHP]). The definition of a GHP is: A health plan that provides health coverage to employees, former employees, and their families, and is supported by an employer or employee organization.

Benefits of the MSP Program

The successful implementation of the MSP Program has resulted in positive benefits for Medicare, the physician, and the patient. Benefits include the following:

- National program savings - Claims are paid by insurers that are primary to Medicare, resulting in a national program savings in excess of 4.5 billion dollars annually.
- Increased revenue - A physician that bills insurance that is primary to Medicare is entitled to bill full charges; receiving more favorable reimbursement is an advantage to physicians. In many instances, insurance companies that are primary will pay more than the amount authorized under Medicare.
- Lower out-of-pocket expenses - Multiple insurance coverage often reduces the amount a patient is obligated to pay, which includes satisfying deductible amounts and preserving Medicare coverage limits.

When is Medicare Considered Secondary?

Medicare may be considered the secondary payer under certain conditions when services are paid first by:

- Group Health Plans
- Federal Black Lung Program
- Workers' Compensation
- No-fault or Liability Insurance

Health insurance or coverage may change during a course of treatment. Physicians should verify and update insurance eligibility for their Medicare patients to determine if any of these MSP conditions apply.

Determining When Medicare is the Secondary Payer

All healthcare providers and suppliers are required to determine if Medicare is the secondary payer. Medicare becomes a beneficiary's secondary payer when information suggests that other primary insurance may exist. This information may come from claims submitted to Medicare indicating other health insurance or coverage. It may also come from employers or insurers that notify Medicare of other health insurance or coverage. In these instances, the beneficiary's MSP records will show that other insurance is primary to Medicare. Claims are then processed according to MSP guidelines.

Request for MSP Information

To determine if Medicare is a beneficiary's secondary payer, physician offices must screen all patients for other primary insurance information. A suggested method for obtaining this information is to incorporate an MSP questionnaire into all patient health records.

Updating Medicare as Primary Payer

Carriers and the COBC require the beneficiary to furnish information about his or her primary insurance. Beneficiaries restoring Medicare as the primary payer may seek assistance from their physician's billing office or current/former employer in obtaining information needed by the carrier or the COBC.

Some information must be documented in writing before Medicare or the COBC can update the patient's records. The local Medicare carrier or the COBC can determine if the beneficiary's information can be updated via telephone or must be documented in writing.

Updating Beneficiary MSP Records

Evidence of a beneficiary's lack of current employment status or a determination of noncoverage through other health insurance or coverage, establishing Medicare as the primary payer, will result in the following:

- A Medicare carrier or the COBC will terminate corresponding MSP records, making Medicare the primary payer
- Pending claims awaiting MSP information will be released for processing
- All claims denied based on suspected MSP involvement will be reprocessed

Medicare Deductibles and MSP Claims

Medicare deductibles are based on Medicare allowable charges, not the amount paid by the primary insurer. If the primary insurer pays the entire amount of a claim but the beneficiary has not satisfied his or her Medicare deductible, then the amounts paid by the primary payer may be credited to the beneficiary's unmet Medicare deductible.

Limiting Charges and MSP Claims

Nonparticipating physicians who do not accept assignment are prohibited from billing or collecting amounts above the applicable limiting charge whether Medicare is primary or secondary and regardless of who pays the claim. For this reason, physicians are encouraged not to exceed Medicare's limiting charge when billing nonassigned claims to another insurer as primary payer and to Medicare Part B as secondary payer.

Note: The mandatory assignment rules for drugs, biologicals, and clinical laboratory services apply when sending a claim to Medicare whether the claim is filed to Medicare as primary or secondary payer.

Filing MSP If Primary Insurer Pays More Than Medicare Allows

Primary insurers sometimes pay more than Medicare allows. Carriers encourage physicians to submit claims for secondary benefits to Medicare in these situations, to allow for proper crediting of any unmet deductibles and to capture savings realized by the presence of MSP records.

Benefits of Submitting Claims to Medicare for Consideration of Secondary Payment:

Because secondary payment is based on the higher of the primary insurer's or Medicare's allowed amount, Medicare may make a secondary payment in addition to the primary insurer's payment. Amounts may be posted to the beneficiary's unmet Medicare deductible, although no secondary payment is made to the physician.

Conditional Payments

Conditional payments by Medicare generally occur in liability, no-fault, and workers' compensation (WC) cases. If the liability, no-fault, or WC insurer will not pay "promptly," Medicare may process the claim with the condition that when the case is resolved, Medicare will recover from the proceeds of the settlement judgment or award.

Duplicate Billing

In liability cases, during the 120-day promptly period, providers and suppliers must bill only the liability insurer unless they have evidence that the liability insurance will not pay within the 120-day promptly period. If they have such evidence, they may bill Medicare for conditional payment. After the 120-day promptly period has ended, they may, but are not required, to bill Medicare for conditional payment if the liability insurance claim is not finally resolved. If they choose to bill Medicare,

they must withdraw claims against the liability insurer or a lien placed on the Medicare beneficiary's settlement. If they choose to continue their claim against the liability settlement, they may not also bill Medicare. This is duplicate billing and is not permissible.

Telling Medicare About MSP Mistaken Payments/Refunds

If Medicare processes and mistakenly makes primary payment and the physician receives primary payment from other insurance primary to Medicare, a refund of the mistaken payment must be made to the carrier. This may be accomplished through submittal of an adjustment claim.

Reprocessing Claims Denied as MSP

Claims denied by Medicare due to other insurance involvement may be reprocessed if no other insurance is primary to Medicare. The physician should first instruct the beneficiary to contact the COBC if there are questions regarding whether an MSP record has been updated. The COBC will then make any necessary updates to the beneficiary's file. The beneficiary should then contact the Medicare carrier to have any denied claims resulting from the former MSP situations reprocessed. The beneficiary may either telephone or write the Medicare carrier to have claims previously denied due to MSP involvement reprocessed. Once a beneficiary's file has been updated to reflect Medicare as the primary payer, all claims that were previously denied due to MSP may be reopened by the Medicare carrier, assuming the request has been made within the requisite time periods. However, until this information is updated in the beneficiary's file, payment may continue to be denied for subsequent claims. Some information must be documented in writing before Medicare can update the patient's records. The local Medicare carrier or the COBC can determine if the beneficiary's information can be updated via telephone or must be documented in writing.

Potential Penalties for Noncompliance

Noncompliance with the MSP Program may result in penalties for the physician and/or private insurers.

- Medicare requires physicians to identify payers primary to Medicare on all claims.
- Physicians can be assessed with civil penalties of up to \$2,000 each for knowingly, willfully, and repeatedly providing inaccurate information relating to the existence of other benefit plans.

Chapter 5 - PART B POLICIES

This section introduces covered and excluded services processed by Medicare Part B, as well as legislative regulations that affect claims filed to the Medicare Part B Program.

Overview

Generally, Medicare pays for services that are considered medically reasonable and necessary to the overall diagnosis and treatment of a patient's condition. Services or supplies are considered medically necessary if they:

- Are proper and needed for the diagnosis or treatment of the patient's medical condition
- Are provided for the diagnosis, direct care, and treatment of the patient's medical condition
- Meet the standards of good medical practice
- Are not mainly for the convenience of the patient or the physician

For every service billed, the physician must indicate the specific sign, symptom, or patient complaint necessitating the service.

Although a service or test may be considered good medical practice, Medicare prohibits payment for services without symptoms or complaints. Services that are considered screening services or routine/preventive in nature are usually excluded. However, Medicare does pay for specific routine screenings, such as Pap tests, screening mammogram services, and colorectal cancer screening services. See the "Preventive Services" section of this chapter for more information.

Medicare Part B Physician Services

Medicare covers a physician's professional services when rendered in the United States and performed in the home, office, institution, or scene of an accident. A patient's home is considered to be anywhere he or she resides (e.g., a home for the aged, a nursing home, or a relative's home).

Covered physician services include but are not limited to:

- Physician's services, including surgery, consultation, office, institutional calls, and services and supplies furnished incident to a physician's professional service
- Outpatient hospital services furnished incident to physician services
- Outpatient diagnostic services furnished by a hospital
- Outpatient physical therapy and outpatient speech pathology
- Diagnostic X-ray tests, laboratory tests, and other diagnostic tests
- X-ray, radium, and radioactive isotope therapy
- Surgical dressings and splints, casts, and other devices used for reduction of fractures and dislocations
- Rental or purchase of durable medical equipment for use in the patient's home
- Ambulance services
- Prosthetic devices that replace all or part of an internal body organ
- Leg, arm, back, and neck braces, artificial legs, arms, and eyes
- Certain medical supplies used in connection with home dialysis delivery systems

- Rural health clinic services
- Ambulatory surgical center services

“Incident to” Provision

Medicare Part B covers services rendered by physicians or auxiliary personnel under the physician’s direct supervision. Auxiliary personnel are known as individuals who act under the supervision of a physician, regardless of whether the individual is an employee, leased employee, or independent contractor of the physician, or of the legal entity that employs or contracts with the physician. Likewise, the supervising physician may be an employee, leased employee, or independent contractor of the legal entity billing and receiving payment for the services or supplies. Certain conditions must be met:

- These services and supplies are those commonly furnished in an office setting. The services are furnished as an integral, although incidental, part of the physician’s professional services in the course of the diagnosis or treatment of an injury or illness and require direct personal physician supervision.
- A valid employment arrangement must exist between the physician/clinic and the employee, by employing a full-time, part-time, or leased employee of the supervising physician or physician group practice, or of the legal entity employing the physician.

Office Setting or Physician-Directed Clinic

“Incident to” services in an office setting or physician-directed clinic must be rendered under direct supervision of the physician. This does not mean that the physician must be present in the same room with his or her auxiliary personnel. However, the physician must be in the office suite and immediately available to provide assistance and direction throughout the time the auxiliary personnel is performing services.

Institution or Other Facility Setting

Medicare cannot assume the physician and nonphysician practitioner will be in close proximity to one another. Therefore, “incident to” services can be covered only if the physician accompanies him or her to treat the patient and directly supervises the services (“over-the-shoulder” supervision).

“Incident to” services provided by the physician’s auxiliary staff in the hospital setting are covered as part of the Part A hospital stay; therefore, Medicare Part B does not reimburse the physician.

Home Care

“Incident to” rules that apply in an office setting apply to the patient’s personal residence, if the physician is present. However, certain rules apply if the physician is not present at the patient’s home. Medicare may reimburse services provided “incident to” a physician’s professional service(s) in the patient’s home, when certain conditions are met.

- The patient is homebound and unable to travel for routine medical services.
- The patient resides in a medically under-served area (a list of medically under-served areas is available through the local Medicare contractor).
- The patient lives in an area not readily accessible to a home health agency.
- The employee is under general supervision of the physician. The physician is immediately available by telephone to collaborate with the employee providing the service.
- Only limited, defined services may be provided in the patient’s home:

- Injections
- Venipuncture
- Electrocardiogram (EKG)
- Therapeutic exercises
- Insertion and sterile irrigation of a catheter
- Changing of catheters and collection of catheterized specimen for urinalysis and culture
- Dressing changes (e.g., the most common chronic conditions which may need dressing changes are decubitus care and gangrene)
- Replacement and/or insertion of nasogastric tubes
- Removal of fecal impaction, including enemas
- Sputum collection for gram stain and culture, and possible acid-fast and/or fungal stain and culture
- Paraffin bath therapy for hands and/or feet in rheumatoid arthritis or osteoarthritis
- Teaching and training the patient for:
 - The care of colostomy and ileostomy
 - The care of permanent tracheostomy
 - Testing urine and care of the feet (diabetic patients only)
 - Blood pressure monitoring

Services By Nonphysician Practitioners

Medicare law covers services furnished by nonphysician practitioners (e.g., nurse practitioners, physician assistants, licensed clinical social workers, etc.), without the direct supervision of a physician. When a nonphysician practitioner renders services not under direct supervision, specific coverage restrictions and/or billing requirements may apply. Reimbursement is based on a reduced percentage of the physician fee schedule amount, or the scope of coverage may be limited, based on licensure and state requirements (e.g., diagnostic tests).

However, if nonphysician practitioner services are to be reported and covered under the “incident to” provision, the direct physician supervision requirement applies, as well as all other “incident to” requirements.

Common Physician Services

Consultations

A consultation is the advice or opinion of one physician to another. A consultation is primarily performed at the request of a referring physician. The consultant examines the patient and prepares a report of his or her findings, which is provided to the referring physician for use in treating the patient. If the intent of the visit is to see the patient and provide the referring physician with advice or an opinion, then consultation procedure codes are used.

Documentation requirements for consultations include:

- History, examination, and medical decision making components to support the level of care billed;

- A written report, provided to the attending/referring physician for inclusion in the patient's permanent medical record; and
- A statement in the requesting physician's record on advice or opinion being sought.

The request and the need for advice or opinion must be documented in the patient's medical record. The consultant's opinion/advice and any services or tests performed should also be documented and communicated to the referring physician.

A consultant may initiate diagnostic treatments and/or therapeutic services. However, if the consultant assumes responsibility for the patient, he or she should then use appropriate procedure codes for *established* or *subsequent* patient visits, based on the place of service, rather than consultation procedure codes.

- All consultation codes billed to Medicare must contain the referring physician's name and Unique Physician/Practitioner Identification Number (UPIN).
- Not all consultations are initiated by a referring physician. The patient and/or family member may initiate a confirmatory consultation, to obtain a second or third opinion. The physician performing the service should use his or her name and UPIN in the appropriate areas on the claim.
- Any identifiable procedure or service performed on or subsequent to the date of the initial consultation should be reported separately.

Concurrent Care

Concurrent care exists when certain evaluation and management (E/M) services are rendered by more than one physician with the same or similar specialty on the same date of service.

Reasonable and necessary services of each physician rendering concurrent care could be covered when each is required to play an active role in the patient's treatment -- for example, due to the existence of medical conditions requiring diverse specialized medical services.

To find concurrent physicians' services reasonable and necessary, the carrier must determine:

- If the patient's condition warrants the services of more than one physician, with the same or similar specialty, on an attending (rather than consultative) basis; and
- If the individual services provided by each physician are reasonable and necessary.

Before determining payment, carriers consider the physician's specialty, as well as the patient's diagnosis.

Physician specialties indicate the necessity for concurrent services, but the carrier's medical staff must also consider the patient's condition and the inherent reasonableness and necessity of the services. For example, although cardiology is a subspecialty of internal medicine, the treatment of both diabetes and a serious heart condition might require the concurrent services of two physicians, each practicing in internal medicine but specializing in different subspecialties.

A patient may occasionally require the services of two physicians with the same specialty or subspecialty, if one physician has limited his or her practice to a unique aspect of that specialty. If the medical documentation does not substantiate the need for more than one physician's service, payment will not be made for the other physician's services.

Telehealth Services

Section 223 of the Benefits Improvement and Protection Act (BIPA) of 2000 provides coverage and payment for Medicare telehealth, which includes consultations, office visits, individual psychotherapy, and pharmacologic management delivered via a telecommunications system. Eligible geo-

graphic areas include rural Health Professional Shortage Areas (HPSA), counties not in a Metropolitan Statistical Area (MSA), and Federal telemedicine demonstration projects approved by or receiving funding from the Secretary of Health and Human Services as of December 31, 2000, regardless of their location.

An interactive telecommunications system is required as a condition of payment. However, BIPA allows the use of asynchronous “store and forward” technology in delivering these services when the originating site is a Federal telemedicine demonstration program in Alaska or Hawaii and does not require that the patient be present.

The term *interactive telecommunications* system means multimedia communications equipment that permits real-time communication between the distant site practitioner (i.e., where the expert physician or practitioner is located at the time the service is provided) and the patient.

“Store and forward” is the asynchronous transmission of medical information to be reviewed at a later time by a physician or practitioner at the distant site. A patient’s medical information may include, but is not limited to: video clips, still images, X-rays, Magnetic Resonance Imaging (MRI), electrocardiogram (EKG), electroencephalogram (EEG), laboratory results, audio clips, and text. The physician or practitioner at the distant site reviews the case without the patient being present. Store and forward substitutes for an interactive encounter with the patient present; the patient is not present in real-time.

Note: Asynchronous telecommunications system in single media format does not include telephone calls, images transmitted via facsimile machines, and text messages without visualization of the patient (electronic mail). Photographs must be specific to the patient’s condition and adequate for rendering or confirming a diagnosis and/or treatment plan.

An originating site is the location of an eligible Medicare beneficiary at the time the service is provided via a telecommunications system. Originating sites authorized by law are:

- Office of a physician or practitioner
- Hospital
- Critical access hospital
- Rural health clinic
- Federally qualified health center

Patients are eligible for telehealth services only if they are presented from an originating site located in either a rural HPSA or in a county outside of a MSA.

As a condition of Medicare Part B payment for telehealth services, the physician or practitioner at the distant site must be licensed to provide the service under state law. Medicare practitioners who may bill for covered telehealth services are:

- Physician
- Nurse practitioner
- Physician assistant
- Nurse midwife
- Clinical nurse specialist
- Clinical psychologist
- Clinical social worker

Note: Clinical psychologists and clinical social workers cannot bill for psychotherapy services that include medical E/M services under Medicare.

Medicare payment for telehealth services is equal to the current fee schedule allowance for the service provided (the same amount that would be allowed if the services were furnished without the use of a telecommunications system). The patient is responsible for any unmet deductible amount and coinsurance.

Modifier (two-digit alpha/numeric code that affects reimbursement used in conjunction with a procedure code) *GT* (via interactive audio and video telecommunication systems) should be used when reporting these services. By using modifier *GT* to bill for the telehealth service, the distant site practitioner verifies that the patient was located at an eligible originating site at the time of the telehealth service.

Modifier *GQ* (via asynchronous telecommunications system) should be used when reporting these services. By using modifier *GQ*, the distant site practitioner verifies that the asynchronous medical file was collected and transmitted to the physician or practitioner at the distant site from a Federal telemedicine demonstration project conducted in Alaska or Hawaii.

Diagnostic Tests – Personally Performed or Purchased

Diagnostic tests assist in identifying the nature and underlying cause of illness. They include services such as X-ray, EEG, cardiac monitoring, and ultrasound. The physician may personally perform these tests, or his or her employee may perform them under the physician's direct supervision, or they may be *purchased*.

Purchased tests are *not* rendered personally by the physician or by his or her employee under the physician's direct supervision. Tests administered by supplier personnel, at the physician's office or at another location, are considered purchased tests. A physician's financial interest in the supplier, perhaps as a limited partner or stockholder, does not change the consideration that these are *purchased tests*.

Diagnostic tests may be billed in one of five ways:

- Global billing
- Technical component only
- Professional component only
- Purchased technical component
- Purchased professional component

Global Billing

These diagnostic tests include situations where the same physician performs the test and interprets the results. When billing globally, the physician must have either:

- Personally performed both the professional and the technical components, or
- Personally performed the professional component and supervised his or her own employee(s) who performed the technical component.

Technical Component Only

These diagnostic tests include situations where the physician performs the test but does not interpret the results. Physicians should indicate modifier *TC* (technical component) on the claim form to identify these services.

Professional Component Only

These diagnostic tests include situations when the physician interprets but does not perform the test. Physicians should indicate modifier 26 (professional component) on the claim form to identify these services.

Purchased Technical Component

A technical component purchased from an outside supplier should be submitted as a separate item on a claim. Claims for purchased technical services must include modifier WU (purchased test) and the name, address, and Medicare provider number of the supplier rendering the test. The amount paid to the supplier for the test must also be indicated on the claim in block 20 of Form CMS-1500 or the designated electronic field. Failure to provide all required information will cause denial of the claim. If more than one supplier is used or more than one test purchased, separate claims must be submitted.

Purchased Professional Component

A professional component (interpretation) of a diagnostic test purchased from an independent physician or medical group will be reimbursed only if:

- The tests are initiated by a physician or medical group that is independent of the person or entity providing the tests/interpretations;
- The person or entity requesting payment submits a claim;
- The physician or medical group providing the interpretation does not see the patient; and
- The purchaser (employee, partner, or owner of the purchaser) performs the technical component of the test. The interpreting physician must be enrolled in the Medicare Program.

The supplier must identify, in the appropriate claim fields, the name, address, and Medicare provider number for the physician providing the interpretation.

For all purchased services, the acquisition cost (the amount paid for the service) must be provided to the carrier, in block 20 of Form CMS-1500 or the designated electronic field. Failure to provide this information will cause denial of the claim.

The purchaser must keep on file the name, the provider identification number, and address of the interpreting physician.

Note: The ordering physician's name and UPIN must be shown on all diagnostic test claims.

EKG and X-Ray Interpretations

When a need exists to provide a medically necessary X-ray or EKG to an emergency room patient, the following guidelines apply:

- Payment will be made for the interpretation and report that directly contributed to the diagnosis and treatment of the patient.
- Hospitals are encouraged to work with medical staff to ensure that only one interpretation charge is submitted per service. If the hospital physician's repeat reading is for quality control and/or liability purposes only, such services are included in the Part A reimbursement and are not separately reimbursed.

Injections/Drugs/Biologicals

Medicare Part B processes claims for injections based on the type of drug injected. Excluding influenza, pneumococcal, and hepatitis B vaccines, three types of injection claims exist:

- Covered injections provided as the only service to the patient

- Covered injections provided during the course of an E/M service
- Excluded injections provided to the patient

When a covered injection is the only service provided, the physician should bill:

- The procedure code for the administration; and
- The procedure code for the drug (when provided by the physician).

If the injection is administered during the course of a covered E/M service, the physician should bill:

- The procedure code for an E/M service; and
- The procedure code for the drug (when provided by the physician).

Note: If an excluded injection is provided to a patient, both the drug and the administration of the drug are excluded items.

Effective for claims processed on or after February 1, 2001, under section 114 of BIPA of 2000, payment for any drug or biological covered under Medicare Part B may be made only on an assignment-related basis. This means the physician or supplier agrees to accept the Medicare fee schedule allowance as payment in full for all covered services. Physicians may collect reimbursement for excluded services, unmet deductible, and coinsurance, from the patient. Additionally, Medicare carriers are required to change the assignment of any nonassigned claim received on or after February 1, 2001. In the event that a nonassigned claim is received that includes services that are subject to mandatory assignment in addition to those that are not, the services subject to mandatory assignment will be separated and processed as if assignment had been accepted.

Psychiatric Services

Psychiatric services and/or E/M services rendered in an office or outpatient setting, with International Classification of Diseases, 9th revision, Clinical Management (ICD-9-CM) diagnosis codes (290-310), are reimbursed at 62.5 percent of the 80 percent Medicare physician fee schedule allowed amount for the service provided. Inpatient psychiatric services are reimbursed at 80 percent of the Medicare physician fee schedule allowed amount.

Preventive Services

Preventive medicine has been addressed by:

- Congress, to insure patient health, thereby reducing Medicare Program expenditures; and
- CMS, to involve physicians in patient care and to enlist their help in educating the public about benefits and coverage policies for preventive immunizations and screenings.

Physicians and healthcare professionals play an important role in utilization of preventive services. A recommendation by a physician is an important influence in determining whether or not beneficiaries decide to be screened. In particular, primary care physicians play a very important role in facilitating compliance with healthcare screenings. Generally, when primary care physicians recommend a screening procedure to patients, patients follow through. Beneficiaries may be unaware of the benefits of screening unless their healthcare professionals discuss them and encourage compliance. Physicians should offer screenings according to currently accepted guidelines and should take advantage of every opportunity to recommend preventive care to patients. Reminders should be given at every visit.

Bone Mass Measurements

The Balanced Budget Act (BBA) of 1997, Section 4106, standardized coverage of bone mass measurements by providing for uniform coverage for services provided on or after July 1, 1998. *Bone mass measurement* is a radiologic or radioisotopic procedure or other procedure that:

- Is performed with a bone densitometer other than Dual Photon Absorptiometry (DPA) or a bone sonometer (e.g., ultrasound) device that has been approved or cleared for marketing by the Food and Drug Administration (FDA);
- Is performed on a qualified individual to identify bone mass, detect bone loss, or determine bone quality; and
- Includes a physician's interpretation of the results of the procedure.

A *qualified individual* is an individual meeting the medical indications for at least one of the five categories below:

- A woman determined by the physician or qualified nonphysician practitioner treating her to be estrogen-deficient and at clinical risk for osteoporosis, based on her medical history and other findings.
- An individual with vertebral abnormalities as demonstrated by X-ray to be indicative of osteoporosis, osteopenia (low bone mass), or vertebral fracture.
- An individual receiving (or expecting to receive) glucocorticoid (steroid) therapy equivalent to 7.5 mg or greater of prednisone per day, for more than three months.
- An individual with primary hyperparathyroidism.
- An individual being monitored to assess response to or efficacy of an FDA-approved osteoporosis drug therapy.

Coverage criteria for bone mass measurements are as follows:

- There must be an order by the individual's physician or qualified nonphysician practitioner treating the patient following an evaluation of the need for a measurement, including a determination as to the medically appropriate measurement to be used for the individual.
- The service must be furnished by a qualified supplier or physician of such services under at least the general level of supervision of a physician.
- The service must be reasonable and necessary for diagnosing, treating, or monitoring a *qualified individual* as defined above.
- The service must be performed with a bone densitometer or a bone sonometer device approved or cleared for marketing by the FDA for bone measurement purposes, with the exception of DPA devices.

Medicare may cover a bone mass measurement for a patient once every two years (if at least 23 months have passed since the last bone mass measurement was performed). However, if medically necessary, Medicare may cover a bone mass measurement for a patient more frequently.

To determine the 23-month period, the count begins with the month after the month in which a previous test or procedure was performed.

For example, the patient received a bone mass measurement test in January 2003. The count starts with February 2003. The patient is eligible to receive another bone mass measurement test in January 2005 (the month after 23 full months have passed).

Examples where more frequent bone mass measurements may be medically necessary include, but are not limited to, the following:

- To monitor patients on long-term glucocorticoid (steroid) therapy
- To allow confirmatory baseline bone mass measurements (central or peripheral) to permit future monitoring of the patient, if the initial test was performed with a technique that is different from the proposed monitoring method. For example, if the initial test was performed with bone sonometry, and monitoring is anticipated using bone densitometry, Medicare will allow coverage of baseline measurement with bone densitometry.

Medicare pays 80 percent of the lower of the approved amount or the submitted charge for bone mass measurement procedures. Deductible and coinsurance apply. Claims from physicians, other practitioners, or suppliers where assignment was not accepted are subject to the Medicare limiting charge.

Diabetes Self-Management Services

The BBA of 1997, Section 4105, permits coverage of diabetes outpatient self-management and training services when a certified provider who meets certain quality standards performs these services. This coverage is effective for services rendered on or after July 1, 1998.

Providers that bill for diabetes outpatient self-management and training services must be certified by the American Diabetes Association (ADA), the Indian Health Service (IHS), or have a Certificate of Recognition from a CMS-approved entity. CMS will accept recognition of the ADA as meeting the National Standards for Diabetes Self-Management Training Programs.

A *diabetes self-management and training service* is a program that educates patients in the successful self-management of diabetes. The program includes education for self-monitoring of blood glucose, diet, exercise, and an insulin treatment plan developed specifically for the insulin-dependent patient. The program also motivates patients toward self-management of the diabetic condition.

Medicare may cover outpatient self-management training services under specific situations:

- If the physician managing the patient's diabetic condition certifies that such services are needed under a comprehensive plan of care to ensure therapy compliance with the patient's diabetic condition.
- To provide the patient with necessary skills and knowledge in managing his or her condition. This includes skills related to self-administration of injectable drugs.

A *Medicare-certified provider* is a physician, other individual, or entity meeting certain quality standards that provides outpatient self-management training services and other Medicare-covered items and services. For purposes of this benefit, services provided by the following may be covered, if all coverage criteria are met: physicians, physician assistants, nurse midwives, clinical psychologists, clinical social workers, hospital outpatient departments, renal dialysis facilities, and durable medical equipment suppliers.

The accreditation organizations, the ADA or IHS, will determine if the program can qualify to have a single-member team. The program may also include a program coordinator, physician advisor, and other trainers. However, only one person or entity from the program bills Medicare for the whole program. The benefit provided by the program may not be subdivided for the purposes of billing Medicare.

Note: On or after January 1, 2002, registered dietitians are eligible to bill on behalf of an entire diabetes self-management training program, as long as the provider has obtained a Medicare provider number. A dietitian may not be the sole provider of the diabetes self-management training service

unless they are performing the service in a rural area as defined in 42 Code of Federal Regulation, section 410.144. Dietitians can be part of a multi-disciplinary team in the diabetes self-management training program.

Medicare pays 80 percent of the lower of the approved amount or the submitted charge for diabetes self-management services. Deductible and coinsurance apply. Claims from physicians, other practitioners, or suppliers where assignment was not accepted are subject to the Medicare limiting charge.

Vaccinations

Pneumococcal (PPV) and Influenza Vaccinations

Medicare began providing coverage for *pneumococcal vaccinations (PPV)* on July 1, 1981, and *influenza vaccinations* on May 1, 1993.

Medicare does not require that a doctor of medicine or osteopathy order the PPV or flu vaccine and its administration. Therefore, the patient may receive the vaccine upon request without a physician's order and without physician supervision. However, for PPV, the physician should still determine the patient's age, health and vaccination status, and obtain a signed consent.

All Medicare patients are eligible to receive an initial PPV vaccination. However, PPV vaccines are typically administered once in a lifetime to persons at high risk of pneumonia infection. Considered at risk are:

- Persons 65 years of age or older;
- Immunocompetent adults who are at increased risk of pneumonia infection or its complications because of chronic illness (e.g., cardiovascular disease, pulmonary disease, diabetes mellitus, alcoholism, cirrhosis, or cerebrospinal fluid leaks); and/or
- Individuals with compromised immune systems (e.g., splenic dysfunction or anatomic asplenia, Hodgkins disease, lymphoma, multiple myeloma, chronic renal failure, HIV infection, nephritic syndrome, sickle cell disease, or organ transplantation).

Reimbursement is made for patients who are at high risk of pneumonia infection and have not received PPV within the last five years or are re-vaccinated because they are unsure of their vaccination status.

Medicare generally pays for *influenza (flu) vaccine* once per season. Based on various flu seasons, this could mean more than one vaccination per year. If a patient is vaccinated twice within the flu season, but for a different strain, Medicare will pay for the second vaccination when supporting documentation proves medical necessity. Medicare does not require a physician be present for the flu vaccination, however individual states may require physician involvement and/or a physician order.

An individual or entity furnishing and administering PPV or flu vaccine to Part B patients may qualify for payment if state licensing and Medicare requirements are met.

The cost of the PPV and flu vaccine and their administration are reimbursed. Medicare pays 100 percent of the lower of the approved amount or the submitted charge for the vaccine and its administration. Deductible and coinsurance do not apply. Claims from physicians, other practitioners, or suppliers where assignment was not accepted are subject to the Medicare limiting charge.

Note: PPV and flu immunizations may be filed to Medicare using traditional billing methods. However, if mass immunizations are furnished to a large number of Medicare beneficiaries, a simplified "roster billing" may be used. Contact the local Medicare carrier for further details regarding "roster billing."

Hepatitis B Vaccinations

Medicare began providing coverage of *hepatitis B vaccine* on September 1, 1984. The vaccine and its administration are covered for Medicare patients at high or intermediate risk of contracting hepatitis B, when ordered by a doctor of medicine or osteopathy.

Medicare pays 80 percent of the lower of the approved amount or the submitted charge for the hepatitis vaccine and its administration. Deductible and coinsurance apply. Claims from physicians, other practitioners, or suppliers where assignment was not accepted are subject to the Medicare limiting charge.

Screening Mammography Services

The BBA of 1997, Section 4101, states screening mammographies are regular, routine radiological examinations for early detection of breast cancer. They include a physician's interpretation of the results. They are conducted as preventive services, when no clinical indications or symptoms exist. A physician's prescription or referral is not required to cover a screening mammogram.

As of January 1, 1991, Medicare covers screening mammography services based on age and frequency of coverage limitations. Starting October 1, 1994, the Mammography Quality Standards Act (MQSA) requires all mammography centers that bill Medicare to be certified by the Food and Drug Administration (FDA). The FDA sends certification information to CMS, which forwards it to individual carriers.

CMS urges carriers to notify physicians under their jurisdiction, at least once a year, about certified mammography centers and, when requested, to provide a list of local covered centers.

The name and number of the mammography center is required in block 32 of Form CMS-1500 or the equivalent electronic claim field.

Requirements for screening mammography services are:

- Women 35-39 are covered for one screening mammogram during that five-year period
- Women 40 and over are covered for one screening mammogram per 12-month period

For women 40 and over, the 12-month time frame is determined as:

- Twelve months have elapsed since the last screening. Counting begins with the month after the last exam. For example, if a woman had an exam on February 25, 2003, counting would begin in March 2003. She would then be eligible for her next screening mammogram on or after February 1, 2004.

Medicare allows a radiologist who interprets screening mammographies to order and interpret additional films based on the results of the screening mammogram while a patient is still at the facility for the screening exam. This can be performed without an additional order from the treating physician. Where a radiologist's interpretation results in additional films, the mammography is no longer considered a screening exam for application of age and frequency standards or payment purposes.

When a screening mammogram is changed to a diagnostic mammogram, based on the interpretation of the radiologist, modifier *GG* (performance and payment of a screening mammogram and diagnostic mammogram on the same patient, same day) should be added to the diagnostic procedure code in block 24f of Form CMS-1500 or the designated electronic field. This modifier is used for statistical purposes in tracking the frequency of this situation. When a screening mammography and a diagnostic mammography are performed for the same patient on the same day, both services will be reimbursed by Medicare.

Medicare pays 80 percent of the lower of the approved amount or the submitted charge for screening mammography services. The Medicare Part B deductible does not apply. However, coinsurance does

apply. Claims from physicians, other practitioners, or suppliers where assignment was not accepted are subject to the Medicare limiting charge.

Screening Pap Tests

The BBA of 1997, Section 4102, provides coverage every three years for screening Pap tests. High risk women are eligible for a Pap test or pelvic exam once every twelve months if they are at high risk for cervical or vaginal cancer or if they are of childbearing age and have had an abnormal Pap test in the preceding 36 months.

Effective July 1, 2001, the Consolidated Appropriations Act of 2001 (P.L. 106-554) modified section §1861(nn) of the Social Security Act (the Act) (42 USC 1395X(nn)) to state that every woman with Medicare coverage is eligible for a screening Pap test once every two years.

Under the following conditions, screening Pap tests are covered when ordered and collected by a doctor of medicine or osteopathy, or other authorized practitioner (i.e., a certified nurse midwife, physician assistant, nurse practitioner, or clinical nurse specialist authorized under state law to perform the examination):

- The patient has not had a screening Pap test during the preceding two years and is at low risk for developing cervical or vaginal cancer.
- Evidence exists, on the basis of medical history or other findings, that she is of childbearing age and has had an examination indicating the presence of cervical or vaginal cancer or other abnormalities during any of the preceding three years; or that she is at high risk of developing cervical or vaginal cancer.

Cervical Cancer High Risk Factors

- Early onset of sexual activity (under 16 years of age)
- Multiple sexual partners (five or more in a lifetime)
- Sexual partners who have multiple sexual partners
- History of a sexually transmitted disease (including HIV infection)
- Fewer than three negative Pap tests within the previous seven years

Vaginal Cancer High Risk Factors

- DES (diethylstilbestrol) - exposed daughters of women who received DES during pregnancy
- Women (under age 65) who have not had a Pap test in 5 years or more

Medicare pays 100 percent of the lower of the approved amount or the submitted charge for screening Pap test lab tests. Deductible and coinsurance do not apply.

Medicare pays 80 percent of the lower of the approved amount or the submitted charge for Pap test collection procedures. The Medicare Part B deductible does not apply. However, coinsurance does apply.

Claims from physicians, other practitioners, or suppliers where assignment was not accepted are subject to the Medicare limiting charge.

Screening Pelvic Examination

The BBA of 1997, Section 4102, provides for coverage of screening pelvic examinations (including a clinical breast examination) for all female patients, effective January 1, 1998, subject to certain coverage, frequency, and payment limitations. Effective July 1, 2001, the Consolidated Appropria-

tions Act of 2001 (P.L. 106-554) modified section §1861(nn) of the Social Security Act (the Act) (42 U.S.C. 1395X(nn)) to provide Medicare coverage for screening pelvic examinations every two years. A screening pelvic examination should include at least seven of the following eleven elements:

- Inspection and palpation of breasts for masses or lumps, tenderness, symmetry, or nipple discharge
- Digital rectal examination, including sphincter tone, presence of hemorrhoids, and rectal masses
- Pelvic examination (with or without specimen collection for smears and culture) including:
 - External genitalia (e.g., general appearance, hair distribution, or lesions)
 - Urethral meatus (e.g., size, location, lesions, or prolapse)
 - Urethra (e.g., masses, tenderness, or scarring)
 - Bladder (e.g., fullness, masses, or tenderness)
 - Vagina (e.g., general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele, or rectocele)
 - Cervix (e.g., general appearance, lesions, or discharge)
 - Uterus (e.g., size, contour, position, mobility, tenderness, consistency, descent, or support)
 - Adnexa/parametria (e.g., masses, tenderness, organomegaly, or nodularity)
 - Anus and perineum

Medicare Part B pays for a screening pelvic examination if performed by a medical doctor, doctor of osteopathy, clinical nurse midwife, physician assistant, nurse practitioner, or clinical nurse specialist authorized under state law to perform the examination. The examination does not have to be ordered by a physician or other authorized practitioner. Payment may be made for a screening pelvic examination performed on an a-symptomatic woman once every two years.

Medicare may pay for a screening pelvic examination more often than once every two years:

- If evidence exists that she is at high risk (on the basis of her medical history or other findings) of developing cervical cancer or vaginal cancer
- For a woman of childbearing age, who had an examination during any of the preceding two years indicating the presence of cervical or vaginal cancer or other abnormality

Medicare does not pay for a screening pelvic examination for women at high risk or who qualify for coverage under the childbearing provision more often than once every 11 months after the month of the last Medicare-covered screening pelvic examination.

The 11- and 23-month periods start with the month after the month in which the previous test or procedure was performed.

Example: A high risk patient received a screening pelvic examination in January 2003. The count starts with February 2003. She is eligible to receive another pelvic exam in January 2004 (the month after 11 full months have passed).

Medicare pays 80 percent of the lower of the approved amount or the submitted charge for screening pelvic examination procedures. The Medicare Part B deductible does not apply. However, coinsurance does apply. Claims from physicians, other practitioners, or suppliers where assignment was not accepted are subject to the Medicare limiting charge.

Screening for Colorectal Cancer

The BBA of 1997, Section 4104, provided for coverage of various colorectal screening examinations subject to coverage, frequency, and payment limitations. Effective January 1, 1998, Medicare covers colorectal cancer screening tests or procedures for the early detection of colorectal cancer. Effective for services rendered on or after July 1, 2001, the colorectal cancer screening benefit has been expanded to include colonoscopies for Medicare patients who are not at high risk for developing colorectal cancer.

Coverage of colorectal cancer screening includes the following tests/procedures:

- Screening fecal occult blood test
- Screening flexible sigmoidoscopy
- Screening colonoscopy
- Screening barium enema as an alternative to a screening flexible sigmoidoscopy or screening colonoscopy

Following are the coverage criteria for these screenings:

- *Screening fecal occult blood tests* are covered once every 12 months (i.e., at least 11 months have passed following the month in which the last covered screening fecal occult blood test was performed) for beneficiaries who have attained age 50.

A screening fecal occult blood test is a guaiac-based test for peroxidase activity that the patient completes by taking samples from two different sites of three consecutive stools. This screening requires a written order from the patient's *attending physician* (a doctor of medicine or osteopathy who is fully knowledgeable about the patient's medical condition, and who would be responsible for using the results of any examination [test] performed in the overall management of the patient's specific medical problem).

Screening flexible sigmoidoscopies are covered at the following frequencies, for patients who have attained age 50:

- Once every 48 months unless the patient does not meet the criteria for high risk of developing colorectal cancer and he or she has had a screening colonoscopy within the preceding 10 years. If a patient has had a screening colonoscopy within the preceding 10 years, then he or she may have covered a screening flexible sigmoidoscopy only after at least 119 months have passed following the month that he or she received the screening colonoscopy.

Note: If, during the course of a screening flexible sigmoidoscopy, a lesion or growth is detected that results in a biopsy or removal of the growth, the appropriate diagnostic procedure classified as a flexible sigmoidoscopy with biopsy or removal should be billed rather than a screening flexible sigmoidoscopy. A doctor of medicine or osteopathy, physician assistant, nurse practitioner, or clinical nurse specialist must perform this screening.

Screening colonoscopies are covered for an individual of any age. They are covered once every 24 months (i.e., at least 23 months have passed since the month in which the last covered screening colonoscopy was performed) for patients at high risk for colorectal cancer. *High risk* for colorectal cancer means an individual who meets one or more of the following criteria:

- Close relative (sibling, parent, or child) who has had colorectal cancer or an adenomatous polyposis;
- Family history of familial adenomatous polyposis;

- Family history of hereditary nonpolyposis colorectal cancer;
- Personal history of adenomatous polyps;
- Personal history of colorectal cancer; and/or
- Inflammatory bowel disease, including Crohn's Disease and ulcerative colitis.

Effective for services furnished on or after July 1, 2001, screening colonoscopies for individuals not meeting the criteria for being at high risk for developing colorectal cancer are covered when performed under the following conditions:

- At a frequency of once every 10 years (i.e., at least 119 months have passed following the month in which the last covered screening colonoscopy was performed)
- If the individual would otherwise qualify to have a covered screening colonoscopy, but has had a covered screening flexible sigmoidoscopy, then he or she may have a covered screening colonoscopy only after at least 47 months have passed following the month in which the last covered flexible sigmoidoscopy was performed.

Note: If, during the course of a screening colonoscopy, a lesion or growth is detected that results in a biopsy or removal of the growth, the appropriate diagnostic procedure classified as a colonoscopy with biopsy or removal should be billed rather than a screening colonoscopy. A doctor of medicine or osteopathy must perform this screening.

Screening barium enema examinations are covered as an alternative to either a screening sigmoidoscopy or a screening colonoscopy examination. The same frequency parameters specified in the law for screening sigmoidoscopy and screening colonoscopy apply.

For an individual, age 50 or over, who is not at high risk of colorectal cancer, payment may be made for a screening barium enema examination performed after at least 47 months have passed following the month in which the last screening barium enema or screening flexible sigmoidoscopy was performed.

For an individual at high risk for colorectal cancer, payment may be made for a screening barium enema examination performed after at least 23 months have passed following the month the last screening barium enema or the last screening colonoscopy was performed.

The screening barium enema must be ordered in writing after determining that the test is the appropriate screening test. This means that the attending physician must determine for an individual that the estimated screening potential for the barium enema is equal to, or greater than, the screening potential estimated for a screening flexible sigmoidoscopy or a screening colonoscopy. Screening single contrast and double contrast barium enema examinations require a written order from the attending physician.

To determine the 11-, 23-, 47-, and 119-month periods, the count should start with the month after the month in which a previous test or procedure was performed.

For example, the patient received a fecal occult blood test in January 2003. The count should start with February 2003. The patient is eligible to receive another blood test in January 2004 (the month after 11 full months have passed).

Medicare pays 100 percent of the lower of the approved amount or the submitted charge for fecal occult blood tests. Deductible and coinsurance do not apply.

Medicare pays 80 percent of the lower of the approved amount or the submitted charge for all other colorectal cancer screening procedures. Deductible and coinsurance apply.

Claims from physicians, other practitioners, or suppliers where assignment was not accepted are subject to the Medicare limiting charge.

Prostate Cancer Screening Tests and Procedures

The BBA, Section 4103, provides for coverage of certain prostate cancer screening tests and procedures subject to certain coverage, frequency, and payment limitations. Effective for services furnished on or after January 1, 2000, Medicare covers prostate cancer screening tests and procedures for the early detection of prostate cancer, including the following:

- *Screening digital rectal examination (DRE)* – a clinical examination of an individual's prostate for nodules or other abnormalities of the prostate
- *Screening prostate specific antigen (PSA) blood test* – a test that detects the marker for adenocarcinoma of the prostate

Following are the coverage criteria for these screenings:

- DRE is covered if all the following criteria are met:
 - It is performed on a male patient age 50 or older (e.g., services are performed at least one day after the patient attained age 50)
 - It is performed by an doctor of medicine or osteopathy, qualified physician assistant, qualified nurse practitioner, qualified clinical nurse specialist, or qualified certified nurse midwife
 - It is performed no more than once every 12 months (i.e., the month after 11 full months have passed)
- PSA test is covered if all of the following criteria are met:
 - It is performed on a male patient age 50 or older (e.g., services are performed at least one day after the patient attained age 50)
 - It is ordered by the patient's attending physician (doctor of medicine or osteopathy), qualified physician assistant, qualified nurse practitioner, qualified clinical nurse specialist, or qualified certified nurse midwife
 - It is performed no more than once every 12 months (i.e., the month after 11 full months have passed)

Medicare pays 80 percent of the lower of the approved amount or the submitted charge for the DRE. Deductible and coinsurance apply.

Medicare pays 100 percent of the lower of the approved amount or the submitted charge for the PSA test. Deductible and coinsurance do not apply.

Claims from physicians, other practitioners, or suppliers where assignment was not accepted are subject to the Medicare limiting charge.

Screening Glaucoma Services

Section 102 of the BIPA of 2000, provides annual coverage for glaucoma screening for patients in the following risk categories:

- Individuals with diabetes mellitus
- Individuals with a family history of glaucoma
- African-Americans age 50 and over

Effective for services rendered on or after January 1, 2002, Medicare will pay for glaucoma screening examinations when they are furnished by or under the direct supervision in the office setting of an ophthalmologist or optometrist who is legally authorized to perform the services under state law.

Screening for glaucoma is defined to include: (1) a dilated eye examination with an intraocular pressure measurement; and (2) a direct ophthalmoscopy examination, or a slit-lamp biomicroscopic examination. Payment may be made for a glaucoma screening examination that is performed on an eligible patient after at least 11 months have passed following the month in which the last covered glaucoma screening examination was performed.

Medicare pays 80 percent of the lower of the approved amount or the submitted charge for glaucoma screening services. Deductible and coinsurance apply. Claims from physicians, other practitioners, or suppliers where assignment was not accepted are subject to the Medicare limiting charge.

Quick Reference Chart – Medicare Preventive Services

Covered Service	Who is Covered	Patient Liability
Bone Mass Measurements Once every 24 months for qualified individuals and more frequently if medically necessary.	Certain people with Medicare who are at risk for losing bone mass.	20% of the Medicare-approved amount (or a set coinsurance amount) after the yearly Part B deductible.
Colorectal Cancer Screening <ul style="list-style-type: none"> Fecal occult Blood Test -Once every 12 months. Flexible Sigmoidoscopy -Once every 48 months. Colonoscopy -Once every 24 months if at high risk for colon cancer. If not at high risk for colon cancer, once every 10 years, but not within 48 months of a screening flexible sigmoidoscopy. Barium Enema -May be used instead of a sigmoidoscopy or colonoscopy. 	All people with Medicare age 50 and older, except colonoscopy for which there is no minimum age requirement.	<ul style="list-style-type: none"> Nothing for the fecal occult blood test. For all other tests, 20% of the Medicare-approved amount after the yearly Part B deductible. For flexible sigmoidoscopy or colonoscopy, patient pays 20% of the Medicare-approved amount after the yearly Part B deductible if the test is done in a hospital outpatient department.
Diabetes Services <ul style="list-style-type: none"> Coverage for glucose monitors, test strips, and lancets. Diabetes self-management training. 	<ul style="list-style-type: none"> All people with Medicare who have diabetes (insulin and non-insulin dependent). Certain people with Medicare who are at risk for complications from diabetes. Must be ordered by a physician. 	20% of the Medicare-approved amount after the yearly Part B deductible.
Mammogram Screening Once every 12 months. Medicare also covers new digital technologies for mammogram screenings.	All women with Medicare age 40 and older. A baseline mammogram is recommended for women between ages 35 and 39.	20% of the Medicare-approved amount with no Part B deductible.
Pap Test and Pelvic Examination (includes a clinical breast exam) Once every 24 months. Once every 12 months if at high risk for cervical or vaginal cancer, or if childbearing age and have had an abnormal Pap test in the past 36 months.	All women with Medicare.	<ul style="list-style-type: none"> Nothing for the Pap lab test. For Pap test collection and pelvic and breast exams, 20% of the Medicare-approved amount (or a set coinsurance amount) with no Part B deductible.
Prostate Cancer Screening <ul style="list-style-type: none"> Digital Rectal Examination - Once every 12 months. Prostate Specific Antigen (PSA) test - Once every 12 months. 	All men with Medicare age 50 and older (coverage begins the day after the 50 th birthday).	Generally, 20% of the Medicare-approved amount for the digital rectal exam after the yearly Part B deductible. No coinsurance and no Part B deductible for the PSA test.
Vaccinations <ul style="list-style-type: none"> Influenza Vaccine -Annually. Pneumococcal Pneumonia Vaccine (PPV) -Once in a lifetime. Hepatitis B Vaccine -Physician recommendation only. 	All people with Medicare.	Nothing for flu and PPV if the physician accepts assignment. For Hepatitis B vaccine, 20% of the Medicare-approved amount after the yearly Part B deductible.
Glaucoma Screening Once every 12 months.	People with Medicare who are at high risk for glaucoma, including people with diabetes, a family history of glaucoma, or African-Americans who are age 50 and older.	20% of the Medicare-approved amount after the yearly Part B deductible.

Surgery Policies

This section addresses Medicare payment policies applicable to surgical procedures.

Preoperative Services

Section 1862(a)(1)(A) of the Social Security Act requires that in order to qualify for Medicare coverage, a service must be reasonable and necessary for the diagnosis and treatment of illness or injury, or to improve the functioning of a malformed body member. A preoperative service performed due to hospital or malpractice protocol cannot supercede this guideline for Medicare coverage purposes. Medicare will pay for preoperative evaluation and management services, and diagnostic tests if they are medically necessary and meet the documentation requirements of the service rendered.

Global Surgery Policy

Global surgery includes all necessary services normally furnished by a surgeon before, during, and after the procedure. Payment for the surgical procedure includes the preoperative, intraoperative, and postoperative services routinely performed by the surgeon. The global surgery concept is defined as a nationwide equitable payment under the Medicare fee schedule to uniformly administer payment for surgical and related services.

Surgeries are classified into two different categories: major and minor. The global surgery policy applies to both major and minor surgical procedures as defined by their postoperative periods. The global surgery policy applies to surgical procedures for which there are postoperative periods of 0, 10, and 90 days.

Minor surgery is a relatively simple surgical service that involves a readily identifiable surgical procedure and includes variable intraoperative and postoperative services. Minor surgeries have a postoperative period of either 0 or 10 days.

Major surgery is a relatively intense surgical service that involves a readily identifiable surgical procedure and includes variable preoperative, intraoperative, and postoperative services. Major surgeries are further identified by their postoperative period. All major surgical procedures have a 90-day postoperative period that begins immediately following the day of surgery and a 1-day preoperative period. The global period for major surgeries includes the pre- and postoperative periods and the day of surgery.

The approved amount for procedures subject to the global surgery policy includes payment for the following services related to the surgery and provided by the surgeon. The physician must not separately bill the following services to Medicare or the patient:

- Preoperative visits rendered after the decision is made to operate, starting one day prior to surgery for major surgical procedures and the day of surgery for minor procedures;
- Intraoperative services that are usual and necessary parts of the surgical procedure;
- All additional medical or surgical services required of the surgeon during the postoperative period due to complications not requiring a return to the operating room;
- Postsurgical pain management by the surgeon;
- Certain supplies that are a normal part of the surgical procedure;
- Miscellaneous services, such as dressing changes; incision care; removal of operative pack or cutaneous sutures, staples, lines, wires, tubes, drains, casts, and splints; insertion, irrigation, and removal of urinary catheters; routine peripheral intravenous lines, nasogastric, and rectal tubes; changes/removal of tracheostomy tubes; or

- Postoperative visits related to the recovery of the surgery, during the postoperative period of the surgery.

Services not included in the global surgery reimbursement that may be billed separately include:

- Initial evaluation or consultation by the surgeon to determine the need for the surgery;
- Treatment for postoperative complications requiring a return trip to the operating room;
- Visits during the postoperative period that are unrelated to the surgical procedure, unless due to complications from the surgery;
- Treatment for the underlying condition or an added course of treatment not part of the normal recovery from surgery;
- Services of other physicians, except when the surgeon and other physician(s) agree on the transfer of care;
- Clearly distinct surgical procedures during the postoperative period that are not repeat operations or treatment for complications;
- Diagnostic tests and radiological procedures;
- Performance of a more extensive procedure if a less extensive procedure fails;
- Immunosuppressive therapy for organ transplants; or
- Critical care services unrelated to the surgery where a seriously injured or burned patient is critically ill and requires constant attendance of the physician.

Global Surgery Modifiers

Modifier 57

E/M services furnished by the surgeon on the day before or on the day of major surgery, that result in the initial decision to perform the surgery, may be covered separately from the surgery. The E/M service should include modifier 57.

Modifier 25

E/M services furnished on the same day as a minor surgical procedure may be covered separately only if the patient's condition required a significant, separately identifiable E/M service above and beyond the usual pre- and postoperative care associated with the procedure. The E/M service should include modifier 25.

Note: When utilizing modifier 25, the medical record must clearly reflect why the visit was unrelated to the surgical procedure.

Modifier 24

Unrelated E/M services furnished by the same physician in the postoperative period of a major surgical procedure may be covered. The E/M service should include modifier 24.

Note: When utilizing modifier 24, the medical record must clearly reflect why the visit was unrelated to the surgical procedure.

Modifier 58

Modifier 58 supports the billing of staged or related surgical procedures performed during the postoperative period of the first procedure. Modifier 58 is not used to report the treatment of a problem that requires a return to the operating room.

It may be necessary for the physician to add modifier 58 to a surgical procedure performed during the postoperative period if it:

- Was planned prospectively or at the time of the original procedure;
- Was more extensive than the original procedure; or
- Is used for therapy following a diagnostic surgical procedure.

A new postoperative period begins when the next procedure in the series is billed.

Modifier 78

When treatment for complications requires a return trip to the operating room, separate payment may be made for the procedure (whether it is the same or a different procedure). The procedure should include modifier 78.

Modifier 79

Separate payment may be made when a surgical procedure furnished during the postoperative period is unrelated to the previous procedure. The procedure should include modifier 79. A new postoperative period begins when the unrelated procedure is billed.

Note: When utilizing modifier 79, the medical record must clearly reflect why the surgery was unrelated to the previous surgical procedure.

Multiple Surgery

The term *multiple surgery* refers to a situation in which the same physician bills multiple covered surgical procedures on the same day. The Medicare allowance is based on 100 percent of the fee schedule amount for the procedure with the highest fee schedule allowance, and 50 percent of the fee scheduled amount for the second, third, fourth, and fifth procedures. When the same physician performs more than five procedures subject to multiple surgery rules on the same day, medical documentation (e.g., the operative report) must be submitted with the claim.

Bilateral Procedures

A bilateral procedure is one performed on both sides of the body during the same session. The payment rules for bilateral procedures are as follows:

Procedures that are Bilateral in Nature

The fee schedule determines certain procedures to be bilateral in nature, when the:

- Procedure code description specifically states that the procedure is bilateral;
- Procedure code description states that the procedure may be performed either bilaterally or unilaterally; or
- Procedure is typically performed as a bilateral procedure.

It is not necessary to use bilateral surgery modifiers when billing procedure codes that are bilateral in nature, regardless of whether or not the procedure was performed unilaterally or bilaterally.

Procedures Allowed at 150 percent of the Fee Schedule

When procedures that are usually performed on one side of the body are performed bilaterally, payment will be made at the lower of the billed amount or 150 percent of the fee schedule allowance. Claims for these procedures should be billed on a separate line of the claim with modifier 50 (bilateral procedure). This modifier indicates the procedure was performed on both sides of the body.

Procedures Allowed at 100 Percent of the Fee Schedule (Each Procedure)

Certain procedures, when performed bilaterally, are allowed at 100 percent of the fee schedule for each side of the body.

To report these services, either of the following methods may be used:

- The procedure may be billed on a single line of the claim with modifier 50 (bilateral procedure) and the billed amount doubled. The allowance is 200 percent of the fee schedule.
- The procedure may be billed on two separate lines of the claim with modifier *LT* (left) on one line and modifier *RT* (right) on the other. The allowance is 100 percent of the fee schedule for each procedure.

Note: These services may not be billed with *both* modifier 50 and *LT* or *RT*.

All carriers publish lists of procedure codes applicable to the above bilateral rules and may be contacted for further information regarding bilateral procedures.

Assistant Surgeon

An assistant surgeon is a physician who actively assists the physician, in charge of a case, in performing a surgical procedure. Not all surgical procedures are deemed by Medicare to require an assistant surgeon. When one is required, the reimbursement for the surgical procedure may be no more than 16 percent of the fee schedule allowance. These services require the use of modifier 80 (assistant surgeon). A list of services that permit an assistant surgeon may be obtained from the local Medicare carrier.

Note: Assistant surgeon reimbursement for multiple procedures is allowed at eight percent of the scheduled allowance for the second through fifth additional covered procedures and on a “by report” basis for additional surgical services (over five) provided to the patient on the same day. Medical documentation (e.g., the operative report) must be submitted with the claim.

Medicare does not cover assistant surgeon charges for procedures where, based on a national average, assistant surgeons are used in fewer than five percent of the cases. The physician may not charge the patient for these services.

Co-Surgeons and Surgical Teams**Co-Surgeons**

Under some circumstances, the individual skills of two or more surgeons are required to perform surgery on the same patient during the same operative session. This may be required because of the complex nature of the procedure and/or the patient’s condition. In these cases, the physicians are acting as co-surgeons.

All carriers publish lists of procedures applicable to co-surgery requirements. Since the services of a co-surgeon could be considered not medically necessary, advance notice of Medicare’s possible denial must be provided to the patient when the surgeons do not wish to accept financial responsibility for the service.

- If two surgeons (each in a different specialty) are required to perform a specific procedure, each surgeon bills for the procedure with modifier 62 (two surgeons). Co-surgery also refers to surgical procedures involving two surgeons performing the parts of the procedure simultaneously, i.e., heart transplant or bilateral knee replacement. Documentation of the medical necessity for two surgeons is required for certain services.

Note: If surgeons of different specialties are each performing different procedures, neither co-surgery nor multiple surgery rules apply (even if the procedures are performed through the same incision). If one of the surgeons performs multiple procedures, the multiple procedure rules apply to that surgeon's services.

Surgical Teams

Surgical teams include several physicians and personnel equipped to perform highly complex procedures. If a team of surgeons (more than two surgeons of different specialties) is required to perform a specific procedure, each surgeon should bill for the procedure with modifier 66 (surgical team). Documentation of the medical necessity for the surgical team is required.

Dermatological Surgery

For certain dermatological services, the procedure code descriptor indicates that multiple surgical procedures have been performed (e.g., removal of skin tags, up to and including 15 lesions). Multiple surgical procedure reimbursement rules do not apply.

For certain other dermatological services, where the procedure code descriptors do not specify that multiple procedures have been performed, reimbursement is based on multiple surgery guidelines.

Therefore, Medicare covers certain surgical procedures performed incidental to other surgical procedures by the surgeon or his or her assistant; however, reimbursement is included in the allowance for the major procedure. Physicians may not charge patients for procedures included in the basic allowance of the major procedure.

Reporting Split Care for Surgery

Physicians Who Furnish the Global Package

In situations where one physician performs a surgical procedure and furnishes all the usual pre- and postoperative services, only the surgical procedure should be billed. Visits or other services included in the global package should not be billed separately.

Physicians Who Furnish Part of the Global Package

In situations where physicians agree on the transfer of care during the global period, each physician will report his or her services by indicating one of the following modifiers on the claim:

- Modifier 54 (Surgical Care Only) should be reported for the surgery only
- Modifier 55 (Postoperative Management Only) should be reported for postoperative care only

Claims for surgical-care-only and postoperative-care-only should indicate the same date of surgery and the same surgical procedure code with the appropriate modifiers. The date(s) on which care was relinquished by one physician and assumed by another physician must be indicated in block 19 of Form CMS-1500 or the designated electronic field.

Services Medicare Does Not Pay For

Medicare does not pay for:

- Services Medicare never covers (services considered excluded);
- Services considered not medically necessary;
- Services denied as bundled or included in the basic allowance of another service; or
- Claims denied as unprocessable.

Excluded Services

The following services are excluded. Medicare never pays for these services, and there is no Medicare fee schedule associated with them. Therefore, the patient may be charged the physician's usual or customary fee for the service, with no Advance Beneficiary Notice required. Please refer to Chapter 8, Waiver of Liability, for more information.

These services include, but are not limited to:

- Acupuncture
- Dental care
- Cosmetic surgery
- Custodial care at home or in a nursing home (assistance with bathing, dressing, etc.)
- Hearing examinations
- Orthopedic shoes
- Outpatient prescription drugs (with only a few exceptions)
- Routine foot care (except for certain people with diabetes)
- Routine eye care
- Routine or annual physical examinations
- Screening tests with no symptoms or documented conditions (exception: preventive screening tests, such as Pap tests, mammograms, and colorectal cancer screening). Please refer to the earlier topic in this chapter, Preventive Services, for more information.
- Vaccinations (with only a few exceptions). Please refer to the earlier topic in this chapter, Preventive Services, for more information.
- Care provided in facilities located outside the United States (except in limited cases) Refer to the note in this section.

Additionally, Medicare does not cover services *related* to excluded services. These include services related to follow-up care and complications of excluded services requiring treatment during a hospital stay in which excluded services were performed. For example, Medicare does not cover routine physical exams and, therefore, does not cover lab tests, or other services *related* to a routine physical exam.

Physicians should use modifier *GY* to indicate that an item or service is not a Medicare benefit.

Note: The term *United States* means the 50 states, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa. For

purposes of services furnished on a ship, this includes territorial waters adjoining the land areas of the United States.

Not Medically Necessary Services

Medicare does not pay for services that are not considered reasonable and necessary for the diagnosis or treatment of an illness or injury. When such services are planned, physicians should ask the patient to sign an Advance Beneficiary Notice. Please refer to Chapter 8, Waiver of Liability, for more information.

Services that are not medically necessary include but are not limited to:

- Services provided in a hospital or Skilled Nursing Facility (SNF) that, based on the patient's condition, could have been provided elsewhere (e.g., the patient's home or a nursing home);
- Hospital or SNF services exceeding Medicare limitations regarding length of stay;
- E/M services in excess of those considered medically reasonable and necessary;
- Therapy or diagnostic procedures in excess of Medicare usage limits; or
- Services not warranted based on the diagnosis of the patient.

Bundled or Basic Allowance Services

Services included in the basic allowance of another procedure are considered *bundled services* and may *not* be charged to the patient. These services include but are not limited to:

- Fragmented services included in the basic allowance of the initial service;
- Prolonged care (indirect);
- Physician standby services;
- Case management services (such as telephone calls to and from patients); and
- Supplies included in the basic allowance of a procedure.

Correct Coding Initiative (CCI)

CMS developed the National Correct Coding Initiative (CCI) to promote national correct coding methodologies and to eliminate improper coding. CCI edits are developed based on coding conventions defined in the American Medical Association's Current Procedural Terminology (CPT) Manual, current standards of medical and surgical coding practice, input from specialty societies, and analysis of current coding practice.

AdminaStar Federal, a CMS contractor, develops and refines the CCI, coordinates the receipt of comments, the prioritization of issues, the review and research of previous actions, and discussions with CMS about concerns.

The CCI identifies code *pairs* based on procedure code descriptions or standard medical practice. These code pairs represent the following:

- *Comprehensive code* – the major procedure or service when reported with another code. The comprehensive code represents greater work, effort, and time as compared to the other code reported.
- *Component code* – the lesser procedure or service when reported with another code. The component code is part of a major procedure or service and is often represented by a lower work relative value unit under the Medicare fee schedule as compared to the other code reported.

The volume of edits in each version update is too large to be produced by Medicare carrier or fiscal intermediaries (FIs) through a Medicare bulletin. Therefore, CMS has designated the National Technical Information Services (NTIS) as the sole distributor of the CCI edits. Subscriptions and single issues are available in various formats, including CD-ROM.

For purchasing information, contact NTIS at www.ntis.gov/products/families/ccl on the Internet, by phone at 1-800-363-2068 (DC area: 703-605-6000), or by writing to the following address:

NTIS Subscriptions Department
5285 Port Royal Road
Springfield, Virginia 22161

Commercial Edits

On October 1, 1998, CMS required contractors to implement commercial procedure-to-procedure edits, to detect *additional* inappropriate procedure code combinations including the following:

- *Mutually exclusive procedure* - two or more procedures not usually performed during the same patient encounter on the same date of service; and
- *Incidental procedure* - procedure that requires little additional physician work and/or is not clinically integral to the performance of the more complex primary procedure being performed at the same time.

These commercial edits are not part of CCI. In addition, because they are proprietary, they are not available to the public through NTIS or in any other format. Physicians may contact the local Medicare contractor for information about these commercial edits.

Chapter 6 - EVALUATION AND MANAGEMENT DOCUMENTATION

This chapter contains the 1995 and 1997 Documentation Guidelines (DGs) for Evaluation and Management (E/M) services. Physicians can choose to use either the 1995 or the 1997 guidelines and carriers must review and adjudicate claims using both the 1995 and the 1997 guidelines.

1995 Documentation Guidelines for E/M Services

I. Introduction

What Is Documentation and Why Is It Important?

Medical record documentation is required to record pertinent facts, findings, and observations about an individual's health history including past and present illnesses, examinations, tests, treatments, and outcomes. The medical record chronologically documents the care of the patient and is an important element contributing to high quality care. The medical record facilitates:

- the ability of the physician and other healthcare professionals to evaluate and plan the patient's immediate treatment, and to monitor his/her healthcare over time;
- communication and continuity of care among physicians and other healthcare professionals involved in the patient's care;
- accurate and timely claims review and payment;
- appropriate utilization review and quality of care evaluations; and
- collection of data that may be useful for research and education.

An appropriately documented medical record can reduce many of the "hassles" associated with claims processing and may serve as a legal document to verify the care provided, if necessary.

What Do Payers Want and Why?

Because payers have a contractual obligation to enrollees, they may require reasonable documentation that services are consistent with the insurance coverage provided. They may request information to validate:

- the site of service;
- the medical necessity and appropriateness of the diagnostic and/or therapeutic services provided; and/or
- that services provided have been accurately reported.

II. General Principles of Medical Record Documentation

The principles of documentation listed below are applicable to all types of medical and surgical services in all settings. For Evaluation and Management (E/M) services, the nature and amount of physician work and documentation varies by type of service, place of service and the patient's status.

The general principles listed below may be modified to account for these variable circumstances in providing E/M services.

1. The medical record should be complete and legible.
2. The documentation of each patient encounter should include:

- reason for the encounter and relevant history, physical examination findings, and prior diagnostic test results;
 - assessment, clinical impression, or diagnosis;
 - plan for care; and
 - date and legible identity of the observer.
3. If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.
 4. Past and present diagnoses should be accessible to the treating and/or consulting physician.
 5. Appropriate health risk factors should be identified.
 6. The patient's progress, response to and changes in treatment, and revision of diagnosis should be documented.
 7. The CPT and ICD-9-CM codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record.

III. Documentation of E/M Services

This publication provides definitions and documentation guidelines for the three **key** components of E/M services and for visits which consist predominately of counseling or coordination of care. The three key components--history, examination, and medical decision making--appear in the descriptors for office and other outpatient services, hospital observation services, hospital inpatient services, consultations, emergency department services, nursing facility services, domiciliary care services, and home services. While some of the text of CPT has been repeated in this publication, the reader should refer to CPT for the complete descriptors for E/M services and instructions for selecting a level of service. **Documentation guidelines are identified by the symbol •DG.**

The descriptors for the levels of E/M services recognize seven components which are used in defining the levels of E/M services. These components are:

- history
- examination
- medical decision making
- counseling
- coordination of care
- nature of presenting problem
- time

The first three of these components (history, examination, and medical decision making) are the **key** components in selecting the level of E/M services. An exception to this rule is the case of visits which consist predominantly of counseling or coordination of care; for these services time is the key or controlling factor to qualify for a particular level of E/M service.

For certain groups of patients, the recorded information may vary slightly from that described here. Specifically, the medical records of infants, children, adolescents, and pregnant women may have additional or modified information recorded in each history and examination area.

As an example, newborn records may include under history of the present illness (HPI) the details of mother's pregnancy and the infant's status at birth; social history will focus on family structure; family history will focus on congenital anomalies and hereditary disorders in the family. In addition, information on growth and development and/or nutrition will be recorded. Although not specifically defined in these documentation guidelines, these patient group variations on history and examination are appropriate.

A. DOCUMENTATION OF HISTORY

The levels of E/M services are based on four types of history (Problem Focused, Expanded Problem Focused, Detailed, and Comprehensive). Each type of history includes some or all of the following elements:

- Chief complaint (CC);
- History of present illness (HPI);
- Review of systems (ROS); and
- Past, family and/or social history (PFSH).

The extent of history of present illness, review of systems, and past, family and/or social history that is obtained and documented is dependent upon clinical judgment and the nature of the presenting problem(s).

The chart below shows the progression of the elements required for each type of history. To qualify for a given type of history, **all three elements in the table must be met.** (A chief complaint is indicated at all levels.)

History of Present Illness (HPI)	Review of Systems (ROS)	Past, Family, and/or Social History (PFSH)	Type of History
Brief	N/A	N/A	<i>Problem Focused</i>
Brief	Problem Pertinent	N/A	<i>Expanded Problem Focused</i>
Extended	Extended	Pertinent	<i>Detailed</i>
Extended	Complete	Complete	<i>Comprehensive</i>

- DG:** *The CC, ROS, and PFSH may be listed as separate elements of history, or they may be included in the description of the history of the present illness.*
- DG:** *A ROS and/or a PFSH obtained during an earlier encounter does not need to be re-recorded if there is evidence that the physician reviewed and updated the previous information. This may occur when a physician updates his/her own record or in an institutional setting or group practice where many physicians use a common record. The review and update may be documented by:*
 - *describing any new ROS and/or PFSH information or noting there has been no change in the information; and*
 - *noting the date and location of the earlier ROS and/or PFSH.*
- DG:** *The ROS and/or PFSH may be recorded by ancillary staff or on a form completed by the patient. To document that the physician reviewed the information, there must be a notation supplementing or confirming the information recorded by others.*
- DG:** *If the physician is unable to obtain a history from the patient or other source, the record should describe the patient's condition or other circumstance which precludes obtaining a history.*

Definitions and specific documentation guidelines for each of the elements of history are listed below.

CHIEF COMPLAINT (CC)

The CC is a concise statement describing the symptom, problem, condition, diagnosis, physician recommended return, or other factor that is the reason for the encounter.

•**DG:** *The medical record should clearly reflect the chief complaint.*

HISTORY OF PRESENT ILLNESS (HPI)

The HPI is a chronological description of the development of the patient's present illness from the first sign and/or symptom or from the previous encounter to the present. It includes the following elements:

- location;
- quality;
- severity;
- duration;
- timing;
- context;
- modifying factors; and
- associated signs and symptoms.

Brief and **extended** HPIs are distinguished by the amount of detail needed to accurately characterize the clinical problem(s).

A **brief** HPI consists of one to three elements of the HPI.

•**DG:** *The medical record should describe one to three elements of the present illness (HPI).*

An **extended** HPI consists of four or more elements of the HPI.

•**DG:** *The medical record should describe four or more elements of the present illness (HPI) or associated comorbidities.*

REVIEW OF SYSTEMS (ROS)

A ROS is an inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms which the patient may be experiencing or has experienced.

For purposes of ROS, the following systems are recognized:

- Constitutional symptoms (e.g., fever, weight loss)
- Eyes
- Ears, Nose, Mouth, Throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary (skin and/or breast)
- Neurological
- Psychiatric
- Endocrine
- Hematologic/Lymphatic
- Allergic/Immunologic

A **problem pertinent** ROS inquires about the system directly related to the problem(s) identified in the HPI.

•**DG:** *The patient's positive responses and pertinent negatives for the system related to the problem should be documented.*

An **extended** ROS inquires about the system directly related to the problem(s) identified in the HPI and a limited number of additional systems.

•**DG:** *The patient's positive responses and pertinent negatives for two to nine systems should be documented.*

A **complete** ROS inquires about the system(s) directly related to the problem(s) identified in the HPI plus all additional body systems.

•**DG:** *At least ten organ systems must be reviewed. Those systems with positive or pertinent negative responses must be individually documented. For the remaining systems, a notation indicating all other systems are negative is permissible. In the absence of such a notation, at least ten systems must be individually documented.*

PAST, FAMILY, AND/OR SOCIAL HISTORY (PFSH)

The PFSH consists of a review of three areas:

- past history (the patient's past experiences with illnesses, operations, injuries and treatments);
- family history (a review of medical events in the patient's family, including diseases which may be hereditary or place the patient at risk); and
- social history (an age appropriate review of past and current activities).

For the categories of subsequent hospital care, follow-up inpatient consultations and subsequent nursing facility care, CPT requires only an "interval" history. It is not necessary to record information about the PFSH.

A **pertinent** PFSH is a review of the history area(s) directly related to the problem(s) identified in the HPI.

•**DG:** *At least one specific item from any of the three history areas must be documented for a pertinent PFSH.*

A **complete** PFSH is of a review of two or all three of the PFSH history areas, depending on the category of the E/M service. A review of all three history areas is required for services that by their nature include a comprehensive assessment or reassessment of the patient. A review of two of the three history areas is sufficient for other services.

•**DG:** *At least one specific item from two of the three history areas must be documented for a complete PFSH for the following categories of E/M services: office or other outpatient services, established patient; emergency department; subsequent nursing facility care; domiciliary care, established patient; and home care, established patient.*

•**DG:** *At least one specific item from each of the three history areas must be documented for a complete PFSH for the following categories of E/M services: office or other outpatient services, new patient; hospital observation services; hospital inpatient services, initial care; consultations; comprehensive nursing facility assessments; domiciliary care, new patient; and home care, new patient.*

B. DOCUMENTATION OF EXAMINATION

The levels of E/M services are based on four types of examination that are defined as follows:

- **Problem Focused** -- a limited examination of the affected body area or organ system.
- **Expanded Problem Focused** -- a limited examination of the affected body area or organ system and other symptomatic or related organ system(s).
- **Detailed** -- an extended examination of the affected body area(s) and other symptomatic or related organ system(s).
- **Comprehensive** -- a general multi-system examination or complete examination of a single organ system.

For purposes of examination, the following **body areas** are recognized:

- Head, including the face
- Neck
- Chest, including breasts and axillae
- Abdomen
- Genitalia, groin, buttocks
- Back, including spine
- Each extremity

For purposes of examination, the following **organ systems** are recognized:

- Constitutional (e.g., vital signs, general appearance)
- Eyes
- Ears, nose, mouth, and throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Skin
- Neurologic
- Psychiatric
- Hematologic/lymphatic/immunologic

The extent of examinations performed and documented is dependent upon clinical judgment and the nature of the presenting problem(s). They range from limited examinations of single body areas to general multi-system or complete single organ system examinations.

- **DG:** *Specific abnormal and relevant negative findings of the examination of the affected or symptomatic body area(s) or organ system(s) should be documented. A notation of "abnormal" without elaboration is insufficient.*
- **DG:** *Abnormal or unexpected findings of the examination of the unaffected or asymptomatic body area(s) or organ system(s) should be described.*
- **DG:** *A brief statement or notation indicating "negative" or "normal" is sufficient to document normal findings related to unaffected area(s) or asymptomatic organ system(s).*
- **DG:** *The medical record for a general multi-system examination should include findings about 8 or more of the 12 organ systems.*

C. DOCUMENTATION OF THE COMPLEXITY OF MEDICAL DECISION MAKING

The levels of E/M services recognize four types of medical decision making (straightforward, low complexity, moderate complexity, and high complexity). Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by:

- the number of possible diagnoses and/or the number of management options that must be considered;
- the amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed; and
- the risk of significant complications, morbidity, and/or mortality, as well as comorbidities associated with the patient's presenting problem(s), the diagnostic procedure(s), and/or the possible management options.

The chart below shows the progression of the elements required for each level of medical decision making. To qualify for a given type of decision making, **two of the three elements in the table must be either met or exceeded.**

Number of diagnoses or management options	Amount and/or complexity of data to be reviewed	Risk of complications and/or morbidity or mortality	Type of decision making
Minimal	Minimal or None	Minimal	<i>Straightforward</i>
Limited	Limited	Low	<i>Low Complexity</i>
Multiple	Moderate	Moderate	<i>Moderate Complexity</i>
Extensive	Extensive	High	<i>High Complexity</i>

Each of the elements of medical decision making is described on the following page.

NUMBER OF DIAGNOSES OR MANAGEMENT OPTIONS

The number of possible diagnoses and/or the number of management options that must be considered is based on the number and types of problems addressed during the encounter, the complexity of establishing a diagnosis, and the management decisions that are made by the physician.

Generally, decision making with respect to a diagnosed problem is easier than that for an identified but undiagnosed problem. The number and type of diagnostic tests employed may be an indicator of the number of possible diagnoses. Problems which are improving or resolving are less complex than those which are worsening or failing to change as expected. The need to seek advice from others is another indicator of complexity of diagnostic or management problems.

•**DG:** *For each encounter, an assessment, clinical impression, or diagnosis should be documented. It may be explicitly stated or implied in documented decisions regarding management plans and/or further evaluation.*

- *For a presenting problem with an established diagnosis the record should reflect whether the problem is: a) improved, well controlled, resolving, or resolved; or, b) inadequately controlled, worsening, or failing to change as expected.*
- *For a presenting problem without an established diagnosis, the assessment or clinical impression may be stated in the form of a differential diagnoses or as "possible," "probable," or "rule out" (R/O) diagnoses.*

- DG:** *The initiation of, or changes in, treatment should be documented. Treatment includes a wide range of management options including patient instructions, nursing instructions, therapies, and medications.*
- DG:** *If referrals are made, consultations requested, or advice sought, the record should indicate to whom or where the referral or consultation is made or from whom the advice is requested.*

AMOUNT AND/OR COMPLEXITY OF DATA TO BE REVIEWED

The amount and complexity of data to be reviewed is based on the types of diagnostic testing ordered or reviewed. A decision to obtain and review old medical records and/or obtain history from sources other than the patient increases the amount and complexity of data to be reviewed.

Discussion of contradictory or unexpected test results with the physician who performed or interpreted the test is an indication of the complexity of data being reviewed. On occasion the physician who ordered a test may personally review the image, tracing, or specimen to supplement information from the physician who prepared the test report or interpretation; this is another indication of the complexity of data being reviewed.

- DG:** *If a diagnostic service (test or procedure) is ordered, planned, scheduled, or performed at the time of the E/M encounter, the type of service, e.g., lab or x-ray, should be documented.*
- DG:** *The review of lab, radiology and/or other diagnostic tests should be documented. An entry in a progress note such as "WBC elevated" or "chest x-ray unremarkable" is acceptable. Alternatively, the review may be documented by initialing and dating the report containing the test results.*
- DG:** *A decision to obtain old records or decision to obtain additional history from the family, caretaker, or other source to supplement that obtained from the patient should be documented.*
- DG:** *Relevant finding from the review of old records, and/or the receipt of additional history from the family, caretaker, or other source should be documented. If there is no relevant information beyond that already obtained, that fact should be documented. A notation of "old records reviewed" or "additional history obtained from family" without elaboration is insufficient.*
- DG:** *The results of discussion of laboratory, radiology, or other diagnostic tests with the physician who performed or interpreted the study should be documented.*
- DG:** *The direct visualization and independent interpretation of an image, tracing, or specimen previously or subsequently interpreted by another physician should be documented.*

RISK OF SIGNIFICANT COMPLICATIONS, MORBIDITY, AND/OR MORTALITY

The risk of significant complications, morbidity, and/or mortality is based on the risks associated with the presenting problem(s), the diagnostic procedure(s), and the possible management options.

- DG:** *Comorbidities/underlying diseases or other factors that increase the complexity of medical decision making by increasing the risk of complications, morbidity, and/or mortality should be documented.*
- DG:** *If a surgical or invasive diagnostic procedure is ordered, planned, or scheduled at the time of the E/M encounter, the type of procedure (e.g., laparoscopy), should be documented.*
- DG:** *If a surgical or invasive diagnostic procedure is performed at the time of the E/M encounter, the specific procedure should be documented.*

- DG:** *The referral for or decision to perform a surgical or invasive diagnostic procedure on an urgent basis should be documented or implied.*

The following table may be used to help determine whether the risk of significant complications, morbidity, and/or mortality is **minimal**, **low**, **moderate**, or **high**. Because the determination of risk is complex and not readily quantifiable, the table includes common clinical examples rather than absolute measures of risk. The assessment of risk of the presenting problem(s) is based on the risk related to the disease process anticipated between the present encounter and the next one. The assessment of risk of selecting diagnostic procedures and management options is based on the risk during and immediately following any procedures or treatment. The highest level of risk in any one category (presenting problem(s), diagnostic procedure(s), or management options) determines the overall risk.

TABLE OF RISK

Level of Risk	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options Selected
Minimal	<ul style="list-style-type: none"> One self-limited or minor problem, e.g., cold, insect bite, tinea corporis 	<ul style="list-style-type: none"> Laboratory tests requiring venipuncture Chest x-rays EKG/EEG Urinalysis Ultrasound, e.g., echocardiography KOH prep 	<ul style="list-style-type: none"> Rest Gargles Elastic bandages Superficial dressings
Low	<ul style="list-style-type: none"> Two or more self-limited or minor problems One stable chronic illness, e.g., well controlled hypertension or non-insulin dependent diabetes, cataract, BPH Acute uncomplicated illness or injury, e.g., cystitis, allergic rhinitis, simple sprain 	<ul style="list-style-type: none"> Physiologic tests not under stress, e.g., pulmonary function tests Non-cardiovascular imaging studies with contrast, e.g., barium enema Superficial needle biopsies Clinical laboratory tests requiring arterial puncture Skin biopsies 	<ul style="list-style-type: none"> Over-the-counter drugs Minor surgery with no identified risk factors Physical therapy Occupational therapy IV fluids without additives
Moderate	<ul style="list-style-type: none"> One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment Two or more stable chronic illnesses Undiagnosed new problem with uncertain prognosis, e.g., lump in breast Acute illness with systemic symptoms, e.g., pyelonephritis, pneumonia, colitis Acute complicated injury, e.g. head injury with brief loss of consciousness 	<ul style="list-style-type: none"> Physiologic tests under stress, e.g., cardiac stress test, fetal contraction stress test Diagnostic endoscopies with no identified risk factors Deep needle or incisional biopsy Cardiovascular imaging studies with contrast and no identified risk factors, e.g., arteriogram, cardiac catheterization Obtain fluid from body cavity, e.g., lumbar puncture, thoracentesis, culdocentesis 	<ul style="list-style-type: none"> Minor surgery with identified risk factors Elective major surgery (open, percutaneous, or endoscopic) with no identified risk factors Prescription drug management Therapeutic nuclear medicine IV fluids with additives Closed treatment of fracture or dislocation without manipulation
High	<ul style="list-style-type: none"> One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment Acute or chronic illnesses or injuries that pose a threat to life or bodily function, e.g., multiple trauma, acute MI, pulmonary embolus, severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure An abrupt change in neurologic status, e.g., seizure, TIA, weakness, or sensory loss 	<ul style="list-style-type: none"> Cardiovascular imaging studies with contrast with identified risk factors Cardiac electrophysiological tests Diagnostic endoscopies with identified risk factors Discography 	<ul style="list-style-type: none"> Elective major surgery (open, percutaneous, or endoscopic) with identified risk factors Emergency major surgery (open, percutaneous, or endoscopic) Parenteral controlled substances Drug therapy requiring intensive monitoring for toxicity Decision not to resuscitate or to de-escalate care because of poor prognosis

D. DOCUMENTATION OF AN ENCOUNTER DOMINATED BY COUNSELING OR COORDINATION OF CARE

In the case where counseling and/or coordination of care dominates (more than 50%) of the physician/patient and/or family encounter (face-to-face time in the office or other outpatient setting or floor/unit time in the hospital or nursing facility), time is considered the key or controlling factor to qualify for a particular level of E/M services.

•**DG:** *If the physician elects to report the level of service based on counseling and/or coordination of care, the total length of time of the encounter (face-to-face or floor time, as appropriate) should be documented and the record should describe the counseling and/or activities to coordinate care.*

1997 Documentation Guidelines for E/M Services

Changes and additions, as they appear in the 1997 guidelines, include the following:

- the contents of general multi-system examinations have been defined with greater clinical specificity;
- documentation requirements for general multi-system examinations have been changed;
- content and documentation requirements have been defined for examinations pertaining to ten organ systems;
- several editorial changes have been made in the definitions of the four types of exams; and
- the definitions of an extended history of present illness have been expanded to include chronic or inactive conditions.

These criteria are used to review medical records for E/M services and to provide documentation required to support a given level of service. The Centers for Medicare & Medicaid Services' goal is to provide physicians and claims reviewers with advice about preparing or reviewing documentation for E/M services. In developing and testing the validity of these guidelines, special emphasis was placed on assuring that they:

- are consistent with the clinical descriptors and definitions contained in Current Procedural Terminology (CPT);
- would be widely accepted by clinicians and would minimize any changes in record-keeping practices; and
- would be interpreted and applied uniformly by users across the country.

Some information and examples have been added for clarity.

I. Introduction

What Is Documentation And Why Is It Important?

Medical record documentation is required to record pertinent facts, findings, and observations about an individual's health history including past and present illnesses, examinations, tests, treatments, and outcomes. The medical record chronologically documents the care of the patient and is an important element contributing to high quality care. The medical record facilitates:

- the ability of the physician and other healthcare professionals to evaluate and plan the patient's immediate treatment, and to monitor his/her healthcare over time.
- communication and continuity of care among physicians and other healthcare professionals involved in the patient's care;
- accurate and timely claims review and payment;
- appropriate utilization review and quality of care evaluations; and
- collection of data that may be useful for research and education.

An appropriately documented medical record can reduce many of the hassles associated with claims processing and may serve as a legal document to verify the care provided, if necessary.

What Do Payers Want and Why?

Because payers have a contractual obligation to enrollees, they may require reasonable documentation that services are consistent with the insurance coverage provided. They may request information to validate:

- the site of service;
- the medical necessity and appropriateness of the diagnostic and/or therapeutic services provided; and/or
- that services provided have been accurately reported.

II. General Principles of Medical Record Documentation

The principles of documentation listed below are applicable to all types of medical and surgical services in all settings. For E/M services, the nature and amount of physician work and documentation varies by type of service, place of service, and the patient's status. The general principles listed below may be modified to account for these variable circumstances in providing E/M services.

1. The medical record should be complete and legible.
2. The documentation of each patient encounter should include:
 - reason for encounter and relevant history, physical examination findings, and prior diagnostic test results;
 - assessment, clinical impression, or diagnosis;
 - plan for care; and
 - date and legible identity of the observer.
3. If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.
4. Past and present diagnoses should be accessible to the treating and/or consulting physician.
5. Appropriate health risk factors should be identified.
6. The patient's progress, response to and changes in treatment, and revision of diagnosis should be documented.
7. The CPT and International Classification of Diseases 9th Revision Clinical Modification (ICD-9-CM) codes reported on the health insurance claim form should be supported by the documentation in the medical record.

III. Documentation of E/M Services

This section provides definitions and documentation guidelines for the three key components of E/M services and for visits that consist predominately of counseling and coordination of care. **Documentation guidelines are identified by the symbol •DG.**

Seven components are used in defining the levels of E/M services:

- History
- Examination
- Medical decision making
- Counseling

- Coordination of care
- Nature of presenting problem
- Time

The first three components (history, examination, and medical decision making) are the key components in selecting the level of E/M services. When visits consist predominantly of counseling or coordination of care, time is the key or controlling factor to qualify for a particular level of E/M service.

Because the level of E/M service is dependent on two or three key components, performance and documentation of one component (e.g., examination) at the highest level does not necessarily mean that the encounter in its entirety qualifies for the highest level of E/M service.

A. DOCUMENTATION OF HISTORY

The levels of E/M services are based on **four levels of history** (problem focused, expanded problem focused, detailed, and comprehensive). Each type of history includes some or all of the following elements:

- Chief complaint (CC)
- History of present illness (HPI)
- Review of systems (ROS) and
- Past, family, and/or social history (PFSH)

The extent of the history of present illness, review of systems, and past, family and/or social history that is obtained and documented is dependent upon clinical judgment and the nature of the presenting problem(s).

The chart on the following page shows the progression of the elements required for each type of history. To qualify for a given type of history, all three elements in the table must be met. (A chief complaint is indicated at all levels.)

•**DG:** *The CC, ROS and PFSH may be listed as separate elements of history, or they may be included in the description of the history of the present illness.*

•**DG:** *A ROS and/or a PFSH obtained during an earlier encounter does not need to be re-recorded if there is evidence that the physician reviewed and updated the previous information. This may occur when a physician updates his/her own record or in an institutional setting or group practice where many physicians use a common record. The review and update may be documented by:*

- *Describing any new ROS and/or PFSH information or noting there has been no change in the information*
- *Noting the date and location of the earlier ROS and/or PFSH*

•**DG:** *The ROS and/or PFSH may be recorded by ancillary staff or on a form completed by the patient. To document that the physician reviewed the information, there must be a notation supplementing or confirming the information recorded by others.*

•**DG:** *If the physician is unable to obtain a history from the patient or other source, the record should describe the patient's condition or other circumstance that precludes obtaining a history.*

HISTORY*(all 3 elements must be met to select a level of history)*

History of Present Illness (HPI)	Review of Systems (ROS)	Past, Family and/or Social History (PFSH)	Type of History
Brief: * 1 - 3 elements (below) must be documented	N/A	N/A	<i>Problem Focused</i>
Brief: * 1 - 3 elements (below) must be documented	Problem Pertinent – System directly related to problem identified in HPI	N/A	<i>Expanded Problem Focused</i>
Extended: * 4 or more elements (below) must be documented	Extended - System directly related to problem identified in HPI and a limited number (2 to 9) of additional systems	Pertinent - At least one specific item from any of the 3 history areas must be documented	<i>Detailed</i>
Extended: * 4 or more elements (below) must be documented <u>Note:</u> Always use the lower of the type of HPI chosen, i.e., the 2nd Brief or the 2nd Extended	Complete - System directly related to problem identified in HPI plus at least 10 additional systems must be reviewed	Complete - 2 or 3 * specific items from any of the 3 history areas must be documented <u>Note:</u> If initial encounter, all 3 (PFSH) must be documented	<i>Comprehensive</i>
Elements	ROS	PFSH Areas	
*Location *Severity *Timing *Modifying Factors *Quality *Duration *Context *Associated Signs and Symptoms	*Constitutional symptoms *Ears, Nose, Mouth, Throat *Respiratory *Genitourinary *Integumentary (skin and/or breast) *Psychiatric *Hematologic/Lymphatic *Eyes *Cardiovascular *Gastrointestinal *Musculoskeletal *Neurological *Endocrine *Allergic/Immunologic	*Past History *Family History *Social History	

Definitions and specific documentation guidelines for each of the elements of history are listed below.

CHIEF COMPLAINT (CC)

The CC is a concise statement describing the symptom, problem, condition, diagnosis, physician-recommended return, or other factor that is the reason for the encounter, usually stated in the patient's own words.

•**DG:** *The medical record should clearly reflect the chief complaint.*

HISTORY OF PRESENT ILLNESS (HPI)

The HPI is a chronological description of the development of the patient's present illness from the first sign and/or symptom or from the previous encounter to the present. It includes the following elements: (Examples are provided for clarity.)

- Location (e.g., where the problem is located)
- Quality (e.g., sharp, dull, stabbing pain)
- Severity (e.g., measured on a scale of 1 - 10)
- Duration (e.g., how long has this problem existed?)
- Timing (e.g., how long does it last, when does it occur?)
- Context (e.g., it hurts when I swallow)
- Modifying factors (e.g., it feels better when I gargle with salt water)
- Associated signs and symptoms (e.g., swelling, redness)

Brief and *extended* HPIs are distinguished by the amount of detail needed to accurately characterize the clinical problem(s).

A *brief* HPI consists of one to three elements of the HPI.

•**DG:** *The medical record should describe one to three elements of the present illness (HPI).*

An *extended* HPI consists of at least four elements of the HPI or the status of at least three chronic or inactive conditions.

•**DG:** *The medical record should describe at least four elements of the present illness (HPI), or the status of at least three chronic or inactive conditions.*

REVIEW OF SYSTEMS (ROS)

A ROS is an inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms that the patient may be experiencing or has experienced.

For purposes of ROS, the following systems are recognized:

- Constitutional Symptoms (e.g., fever, weight loss)
- Eyes
- Ears, Nose, Mouth, and Throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary (skin and/or breast)
- Neurological
- Psychiatric
- Endocrine
- Hematologic/Lymphatic

- Allergic/Immunologic

A *problem pertinent* ROS inquires about the system *directly related* to the problem(s) identified in the HPI.

- **DG:** *The patient's positive responses and pertinent negatives for the system related to the problem should be documented.*

An *extended* ROS inquires about the system directly related to the problem(s) identified in the HPI and a limited number of additional systems.

- **DG:** *The patient's positive responses and pertinent negatives for two to nine systems should be documented.*

A *complete* ROS inquires about the system(s) directly related to the problem(s) identified in the HPI, plus all additional body systems.

- **DG:** *At least ten organ systems must be reviewed. Those systems with positive or pertinent negative responses must be individually documented. For the remaining systems, a notation indicating all other systems are negative is permissible. In the absence of such a notation, at least ten systems must be individually documented.*

PAST, FAMILY, AND/OR SOCIAL HISTORY (PFSH)

The PFSH consists of a review of three areas:

- **Past history** (the patient's past experiences with illnesses, operations, injuries, and treatments);
- **Family history** (a review of medical events in the patient's family, including diseases which may be hereditary or place the patient at risk); and
- **Social history** (an age appropriate review of past and current activities).

For certain categories of E/M services that include only an interval history, it is not necessary to record information about the PFSH. Those categories are subsequent hospital care, follow-up inpatient consultations, and subsequent nursing facility care.

A *pertinent* PFSH is a review of the history area(s) *directly related* to the problem(s) identified in the HPI.

- **DG:** *At least one specific item from any of the three history areas must be documented for a pertinent PFSH.*

A *complete* PFSH is a review of two or all three of the PFSH history areas, depending on the category of the E/M service. A review of *all three* history areas is required for services that by their nature include a comprehensive assessment or reassessment of the patient. A review of *two of the three* history areas is sufficient for other services.

- **DG:** *At least one specific item from two of the three history areas must be documented for a complete PFSH for the following categories of E/M services:*

- *Office or Other Outpatient Services – Established Patient*
- *Emergency Department*
- *Domiciliary Care – Established Patient*
- *Home Care – Established Patient*

- **DG:** *At least one specific item from each of the three history areas must be documented for a complete PFSH for the following categories of E/M services:*

- *Office or Other Outpatient Services – New Patient*
- *Hospital Observation Services*
- *Hospital Inpatient Services – Initial Care*
- *Consultations*
- *Comprehensive Nursing Facility Assessments*
- *Domiciliary Care – New Patient*
- *Home Care – New Patient*

B. DOCUMENTATION OF EXAMINATIONS

The levels of E/M services are based on **four types of examinations**:

- ***Problem Focused*** – Limited examination of the affected body area or organ system
- ***Expanded Problem Focused*** – Limited examination of the affected body area or organ system and any other symptomatic or related body area(s) or organ system(s)
- ***Detailed*** – Extended examination of the affected body area(s) or organ system(s) and any other symptomatic or related body area(s) or organ system(s)
- ***Comprehensive*** – General multi-system examination, or complete examination of a single organ system and other symptomatic or related body area(s) or organ system(s)

These types of examinations have been defined for general multi-system and the following single organ systems:

- Cardiovascular
- Ears, Nose, Mouth, and Throat
- Eyes
- Genitourinary (Female)
- Genitourinary (Male)
- Hematologic/Lymphatic/Immunologic
- Musculoskeletal
- Neurological
- Psychiatric
- Respiratory
- Skin

A general multi-system examination or a single organ system examination may be performed by any physician, regardless of specialty. The type (general multi-system or single organ system) and content of examination are selected by the examining physician and are based upon clinical judgment, the patient's history, and the nature of the presenting problem(s).

The content and documentation requirements for each type and level of examination are summarized below and described in detail in the following tables. In the tables, organ systems and body areas recognized by CPT for purposes of describing examinations are shown in the left column. The content, or individual elements, of the examination pertaining to that body area or organ system are identified by bullets (•) in the right column.

Parenthetical examples “(e.g.,...)” have been used for clarification and to provide guidance regarding documentation. Documentation for each element must satisfy any numeric requirements (such as “Measurement of *any three of the following seven...*”) included in the description of the element. Elements with multiple components but with no specific numeric requirement (such as “Examination of *liver and spleen*”) require documentation of at least one component. It is possible for a given examination to be expanded beyond what is defined here. When that occurs, findings related to the additional systems and/or areas should be documented.

- DG:** *Specific abnormal and relevant negative findings of the examination of the affected or symptomatic body area(s) or organ system(s) should be documented. A notation of “abnormal” without elaboration is insufficient.*
- DG:** *Abnormal or unexpected findings of the examination of any asymptomatic body area(s) or organ system(s) should be described.*
- DG:** *A brief statement or notation indicating “negative” or “normal” is sufficient to document normal findings related to unaffected area(s) or asymptomatic organ system(s).*

GENERAL MULTI-SYSTEM EXAMINATIONS

General multi-system examinations are described in detail in the table on the following page. To qualify for a given level of multi-system examination, the following content and documentation requirements should be met:

- **Problem Focused Examination** should include performance and documentation of **one to five elements** identified by a bullet (•) in one or more organ system(s) or body area(s).
- **Expanded Problem Focused Examination** should include performance and documentation of at least **six elements** identified by a bullet (•) in one or more organ system(s) or body area(s).
- **Detailed Examination** should include **at least six organ systems or body areas**. For each system/area selected, performance and documentation of at least two elements identified by a bullet (•) is expected. Alternatively, a detailed examination may include performance and documentation of **at least twelve elements** identified by a bullet (•) in **two or more organ systems or body areas**.
- **Comprehensive Examination** should include **at least nine organ systems or body areas**. For each system/area selected, **all elements** of the examination identified by a bullet (•) should be performed, unless specific directions limit the content of the examination. For each area/system, documentation of **at least two elements** identified by a bullet is expected.

SINGLE ORGAN SYSTEM EXAMINATIONS

The single organ system examinations recognized by CPT are described in detail in the tables on the following pages. Variations among these examinations in the organ systems and body areas identified in the left columns and in the elements of the examinations described in the right columns reflect differing emphases among specialties.

To qualify for a given level of single organ system examination, the following content and documentation requirements should be met:

- **Problem focused examinations** should include performance and documentation of **one to five elements** identified by a bullet (•), whether in a shaded or unshaded box.

- *Expanded problem focused examinations* should include performance and documentation of **at least six elements** identified by a bullet (•), whether in a shaded or unshaded box.
- *Detailed examinations* are examinations other than the eye and psychiatric examinations and, should include performance and documentation of **at least twelve elements** identified by a bullet (•), whether in a shaded or unshaded box.
 - *Eye and psychiatric examinations* should include the performance and documentation of **at least nine elements** identified by a bullet (•), whether in a shaded or an unshaded box.
- *Comprehensive examinations* should include performance of **all elements** identified by a bullet (•), whether in a shaded or unshaded box. Documentation of every element in a shaded box and at least one element in an unshaded box is expected.

GENERAL MULTI-SYSTEM EXAMINATION

System/Body Area	Elements of Examination
<i>Constitutional</i>	<ul style="list-style-type: none"> Measurement of any three of the following seven vital signs: <ol style="list-style-type: none"> 1) sitting or standing blood pressure 2) supine blood pressure 3) pulse rate and regularity 4) respiration 5) temperature 6) height 7) weight (may be measured and recorded by ancillary staff) General appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming)
<i>Eyes</i>	<ul style="list-style-type: none"> Inspection of conjunctivae and lids Examination of pupils and irises (e.g., reaction to light and accommodation, size and symmetry) Ophthalmoscopic examination of optic discs (e.g., size, C/D ratio, appearance) and posterior segments (e.g., vessel changes, exudates, hemorrhages)
<i>Ears, Nose, Mouth, and Throat</i>	<ul style="list-style-type: none"> External inspection of ears and nose (e.g., overall appearance, scars, lesions, masses) Otoscope examination of external auditory canals and tympanic membranes Assessment of hearing (e.g., whispered voice, finger rub, tuning fork) Inspection of nasal mucosa, septum, and turbinates Inspection of lips, teeth, and gums Examination of oropharynx: oral mucosa, salivary glands, hard and soft palates, tongue, tonsils, and posterior pharynx
<i>Neck</i>	<ul style="list-style-type: none"> Examination of neck (e.g., masses, overall appearance, symmetry, tracheal position, crepitus) Examination of thyroid (e.g., enlargement, tenderness, mass)
<i>Respiratory</i>	<ul style="list-style-type: none"> Assessment of respiratory effort (e.g., intercostal retractions, use of accessory muscles, diaphragmatic movement) Percussion of chest (e.g., dullness, flatness, hyperresonance) Palpation of chest (e.g., tactile fremitus) Auscultation of lungs (e.g., breath sounds, adventitious sounds, rubs)
<i>Cardiovascular</i>	<ul style="list-style-type: none"> Palpation of heart (e.g., location, size, thrills) Auscultation of heart with notation of abnormal sounds and murmurs Examination of: <ul style="list-style-type: none"> carotid arteries (e.g., pulse amplitude, bruits) abdominal aorta (e.g., size, bruits) femoral arteries (e.g., pulse amplitude, bruits)
	<ul style="list-style-type: none"> pedal pulses (e.g., pulse amplitude) extremities for edema and/or varicosities
<i>Chest (breasts)</i>	<ul style="list-style-type: none"> Inspection of breasts (e.g., symmetry, nipple discharge) Palpation of breasts and axillae (e.g., masses or lumps, tenderness)
<i>Gastrointestinal (abdomen)</i>	<ul style="list-style-type: none"> Examination of abdomen with notation of presence of masses or tenderness Examination of liver and spleen Examination for presence or absence of hernia Examination (when indicated) of anus, perineum and rectum, including sphincter tone, presence of hemorrhoids, rectal masses Obtain stool sample for occult blood test when indicated
<i>Genitourinary – Male:</i>	<ul style="list-style-type: none"> Examination of the scrotal contents (e.g., hydrocele, spermatocele, tenderness of cord, testicular mass) Examination of the penis Digital rectal examination of prostate gland (e.g., size, symmetry, nodularity, tenderness)

<i>Genitourinary – Female:</i>	<p>Pelvic examination (with or without specimen collection for smears and cultures), including:</p> <ul style="list-style-type: none"> • Examination of external genitalia (e.g., general appearance, hair distribution, lesions) and vagina (e.g., general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele, rectocele) • Examination of urethra (e.g., masses, tenderness, scarring) • Examination of bladder (e.g., fullness, masses, tenderness) • Cervix (e.g., general appearance, lesions, discharge) • Uterus (e.g., size, contour, position, mobility, tenderness, consistency, descent, or support) • Adnexa/parametria (e.g., masses, tenderness, organomegaly, nodularity)
<i>Lymphatic</i>	<p>Palpation of lymph nodes in two or more areas:</p> <ul style="list-style-type: none"> • neck • axillae • groin • other
<i>Musculoskeletal</i>	<ul style="list-style-type: none"> • Examination of gait and station • Inspection and/or palpation of digits and nails (e.g., clubbing, cyanosis, inflammatory conditions, petechiae, ischemia, infections, nodes) <p>Examination of joints, bones, and muscles of one or more of the following six areas: 1) head and neck; 2) spine, ribs, and pelvis; 3) right upper extremity; 4) left upper extremity; 5) right lower extremity; and 6) left lower extremity. The examination of a given area includes:</p> <ul style="list-style-type: none"> • Inspection and/or palpation with notation of presence of any misalignment, asymmetry, crepitation, defects, tenderness, masses, effusions • Assessment of range of motion with notation of any pain, crepitation, or contracture • Assessment of stability with notation of any dislocation (luxation), subluxation, or laxity • Assessment of muscle strength and tone (e.g., flaccid, cog wheel, spastic) with notation of any atrophy or abnormal movements
<i>Skin</i>	<ul style="list-style-type: none"> • Inspection of skin and subcutaneous tissue (e.g., rashes, lesions, ulcers) • Palpation of skin and subcutaneous tissue (e.g., induration, subcutaneous nodules, tightening)
<i>Neurologic</i>	<ul style="list-style-type: none"> • Test cranial nerves with notation of any deficits • Examination of deep tendon reflexes with notation of pathological reflexes (e.g., Babinski) • Examination of sensation (e.g., by touch, pin, vibration, proprioception)
<i>Psychiatric</i>	<ul style="list-style-type: none"> • Description of patient's judgment and insight <p>Brief assessment of mental status including:</p> <ul style="list-style-type: none"> • orientation to time, place, and person • recent and remote memory • mood and affect (e.g., depression, anxiety, agitation)

CONTENT AND DOCUMENTATION REQUIREMENTS FOR GENERAL MULTI-SYSTEM EXAMINATION

Level of Examination	Perform and Document
<i>Problem Focused</i>	One to five elements identified by a bullet
<i>Expanded Problem Focused</i>	At least six elements identified by a bullet
<i>Detailed</i>	At least two elements identified by a bullet from each of six areas/systems or at least twelve elements identified by a bullet in two or more areas/systems
<i>Comprehensive</i>	Perform all elements identified by a bullet in at least nine organ systems or body areas and document at least two elements identified by a bullet from each of the nine areas/systems

CARDIOVASCULAR EXAMINATION

System/Body Area	Elements of Examination
<i>Constitutional</i>	<ul style="list-style-type: none"> Measurement of any three of the following seven vital signs: <ol style="list-style-type: none"> sitting or standing blood pressure supine blood pressure pulse rate and regularity respiration temperature height weight (may be measured and recorded by ancillary staff) General appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming)
<i>Eyes</i>	<ul style="list-style-type: none"> Inspection of conjunctivae and lids (e.g., xanthelasma)
<i>Ears, Nose, Mouth, and Throat</i>	<ul style="list-style-type: none"> Inspection of teeth, gums, and palate Inspection of oral mucosa with notation of presence of pallor or cyanosis
<i>Neck</i>	<ul style="list-style-type: none"> Examination of jugular veins (e.g., distension; a, v, or cannon a waves) Examination of thyroid (e.g., enlargement, tenderness, mass)
<i>Respiratory</i>	<ul style="list-style-type: none"> Assessment of respiratory effort (e.g., intercostal retractions, use of accessory muscles, diaphragmatic movement) Auscultation of lungs (e.g., breath sounds, adventitious sounds, rubs)
<i>Cardiovascular</i>	<ul style="list-style-type: none"> Palpation of heart (e.g., location, size and forcefulness of the point of maximal impact; thrills; lifts; palpable S3 or S4) Auscultation of heart including sounds, abnormal sounds, and murmurs Measurement of blood pressure in two or more extremities when indicated (e.g., aortic dissection, coarctation) <p>Examination of:</p> <ul style="list-style-type: none"> Carotid arteries (e.g., waveform, pulse amplitude, bruits, apical-carotid delay) Abdominal aorta (e.g., size, bruits) Femoral arteries (e.g., pulse amplitude, bruits) Pedal pulses (e.g., pulse amplitude) Extremities for peripheral edema and/or varicosities
<i>Gastrointestinal (abdomen)</i>	<ul style="list-style-type: none"> Examination of abdomen with notation of presence of masses or tenderness Examination of liver and spleen Obtain stool sample for occult blood from patients who are being considered for thrombolytic or anticoagulant therapy
<i>Musculoskeletal</i>	<ul style="list-style-type: none"> Examination of the back with notation of kyphosis or scoliosis Examination of gait with notation of ability to undergo exercise testing and/or participation in exercise programs Assessment of muscle strength and tone (e.g., flaccid, cog wheel, spastic) with notation of any atrophy and abnormal movements
<i>Extremities</i>	<ul style="list-style-type: none"> Inspection and palpation of digits and nails (e.g., clubbing, cyanosis, inflammation, petechiae, ischemia, infections, Osler's nodes)
<i>Skin</i>	<ul style="list-style-type: none"> Inspection and/or palpation of skin and subcutaneous tissue (e.g., stasis dermatitis, ulcers, scars, xanthomas)
<i>Neurological/Psychiatric</i>	<p>Brief assessment of mental status, including:</p> <ul style="list-style-type: none"> Orientation to time, place, and person Mood and affect (e.g., depression, anxiety, agitation)

CONTENT AND DOCUMENTATION REQUIREMENTS FOR CARDIOVASCULAR EXAMINATION

Level of Examination	Perform and Document
<i>Problem Focused</i>	One to five elements identified by a bullet
<i>Expanded Problem Focused</i>	At least six elements identified by a bullet
<i>Detailed</i>	At least twelve elements identified by a bullet
<i>Comprehensive</i>	Perform all elements identified by a bullet; document every element in each shaded box and at least one element in each unshaded box

EAR, NOSE AND THROAT EXAMINATION

System/Body Area	Elements of Examination
<i>Constitutional</i>	<ul style="list-style-type: none"> • Measurement of any three of the following seven vital signs <ol style="list-style-type: none"> 1. sitting or standing blood pressure 2. supine blood pressure 3. pulse rate and regularity 4. respiration 5. temperature 6. height 7. weight (may be measured and recorded by ancillary staff) • General appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming) • Assessment of ability to communicate (e.g., use of sign language or other communication aids) and quality of voice
<i>Head and Face</i>	<ul style="list-style-type: none"> • Inspection of head and face (e.g., overall appearance, scars, lesions, and masses) • Palpation and/or percussion of face with notation of presence or absence of sinus tenderness • Examination of salivary glands • Assessment of facial strength
<i>Eyes</i>	<ul style="list-style-type: none"> • Test ocular motility, including primary gaze alignment
<i>Ears, Nose, Mouth, and Throat</i>	<ul style="list-style-type: none"> • Otoscopic examination of external auditory canals and tympanic membranes including pneumotoscopy with notation of mobility of membranes • Assessment of hearing with tuning forks and clinical speech reception thresholds (e.g., whispered voice, finger rub) • External inspection of ears and nose (e.g., overall appearance, scars, lesions, and masses) • Inspection of nasal mucosa, septum, and turbinates • Inspection of lips, teeth, and gums • Examination of oropharynx: oral mucosa, hard and soft palates, tongue, tonsils, and posterior pharynx (e.g., asymmetry, lesions, hydration of mucosal surfaces) • Inspection of pharyngeal walls and pyriform sinuses (e.g., pooling of saliva, asymmetry, lesions) • Examination by mirror of larynx including the condition of the epiglottis, false vocal cords, true vocal cords, and mobility of larynx (use of mirror not required in children) • Examination by mirror of nasopharynx including appearance of the mucosa, adenoids, posterior choanae, and eustachian tubes (use of mirror not required in children)
<i>Neck</i>	<ul style="list-style-type: none"> • Examination of neck (e.g., masses, overall appearance, symmetry, tracheal position, crepitus) • Examination of thyroid (e.g., enlargement, tenderness, mass)
<i>Respiratory</i>	<ul style="list-style-type: none"> • Inspection of chest including symmetry, expansion, and/or assessment of respiratory effort (e.g., intercostal retractions, use of accessory muscles, diaphragmatic movement) • Auscultation of lungs (e.g., breath sounds, adventitious sounds, rubs)
<i>Cardiovascular</i>	<ul style="list-style-type: none"> • Auscultation of heart with notation of abnormal sounds and murmurs • Examination of peripheral vascular system by observation (e.g., swelling, varicosities) and palpation (e.g., pulses, temperature, edema, tenderness)
<i>Lymphatic</i>	<ul style="list-style-type: none"> • Palpation of lymph nodes in neck, axillae, groin, and/or other location
<i>Neurological/Psychiatric</i>	<ul style="list-style-type: none"> • Test cranial nerves with notation of any deficits <p>Brief assessment of mental status, including:</p> <ul style="list-style-type: none"> • Orientation to time, place, and person • Mood and affect (e.g., depression, anxiety, agitation)

CONTENT AND DOCUMENTATION REQUIREMENTS FOR EAR, NOSE AND THROAT EXAMINATION

Level of Examination	Perform and Document
<i>Problem Focused</i>	One to five elements identified by a bullet
<i>Expanded Problem Focused</i>	At least six elements identified by a bullet
<i>Detailed</i>	At least twelve elements identified by a bullet
<i>Comprehensive</i>	Perform all elements identified by a bullet; document every element in each shaded box and at least one element in each unshaded box

EYE EXAMINATION

System/Body Area	Elements of Examination
<i>Eyes</i>	<ul style="list-style-type: none"> • Test visual acuity (does not include determination of refractive error) • Gross visual field testing by confrontation • Test ocular motility including primary gaze alignment • Inspection of bulbar and palpebral conjunctivae • Examination of ocular adnexae including lids (e.g., ptosis or lagophthalmos), lacrimal glands, lacrimal drainage, orbits, and preauricular lymph nodes • Examination of pupils and irises including shape, direct and consensual reaction (afferent pupil), size (e.g., anisocoria), and morphology • Slit lamp examination of the corneas including epithelium, stroma, endothelium, and tear film • Slit lamp examination of the anterior chambers including depth, cells, and flare • Slit lamp examination of the lenses including clarity, anterior and posterior capsule, cortex, and nucleus • Measurement of intraocular pressures (except in children and patients with trauma or infectious disease) <p>Ophthalmoscopic examination through dilated pupils (unless contraindicated) of:</p> <ul style="list-style-type: none"> • Optic discs including size, C/D ratio, appearance, (e.g., atrophy, cupping, tumor elevation) and nerve fiber layer • Posterior segments including retina and vessels (e.g., exudates and hemorrhages)
<i>Neurological/Psychiatric</i>	<p>Brief assessment of mental status, including:</p> <ul style="list-style-type: none"> • Orientation to time, place, and person • Mood and affect (e.g., depression, anxiety, agitation)

CONTENT AND DOCUMENTATION REQUIREMENTS FOR EYE EXAMINATION

Level of Examination	Perform and Document
<i>Problem Focused</i>	One to five elements identified by a bullet
<i>Expanded Problem Focused</i>	At least six elements identified by a bullet
<i>Detailed</i>	At least nine elements identified by a bullet
<i>Comprehensive</i>	Perform all elements identified by a bullet; document every element in each shaded box and at least one element in each unshaded box

GENITOURINARY EXAMINATION (MALE OR FEMALE)

System/Body Area	Elements of Examination
<i>Constitutional</i>	<ul style="list-style-type: none"> Measurement of any three of the following seven vital signs: <ol style="list-style-type: none"> sitting or standing blood pressure supine blood pressure pulse rate and regularity respiration temperature height weight (may be measured and recorded by ancillary staff) General appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming)
<i>Neck</i>	<ul style="list-style-type: none"> Examination of neck (e.g., masses, overall appearance, symmetry, tracheal position, crepitus) Examination of thyroid (e.g., enlargement, tenderness, mass)
<i>Respiratory</i>	<ul style="list-style-type: none"> Assessment of respiratory effort (e.g., intercostal retractions, use of accessory muscles, diaphragmatic movement) Auscultation of lungs (e.g., breath sounds, adventitious sounds, rubs)
<i>Cardiovascular</i>	<ul style="list-style-type: none"> Auscultation of heart with notation of abnormal sounds and murmurs Examination of peripheral vascular system by observation (e.g., swelling, varicosities) and palpation (e.g., pulses, temperature, edema, tenderness)
<i>Chest (breasts)</i>	See Genitourinary – FEMALE
<i>Gastrointestinal (abdomen)</i>	<ul style="list-style-type: none"> Examination of abdomen with notation of presence of masses or tenderness Examination for presence or absence of hernia Examination of liver and spleen Obtain stool sample for occult blood test when indicated
<i>Genitourinary - MALE</i>	<ul style="list-style-type: none"> Inspection of anus and perineum <p>Examination (with or without specimen collection for smears and cultures) of genitalia, including:</p> <ul style="list-style-type: none"> Scrotum (e.g., lesions, cysts, rashes) Epididymides (e.g., size, symmetry, masses) Testes (e.g., size, symmetry, masses) Urethral meatus (e.g., size, location, lesions, discharge) Penis (e.g., lesions, presence or absence of foreskin, foreskin retractability, plaque, masses, scarring, deformities) <p>Digital rectal examination including:</p> <ul style="list-style-type: none"> Prostate gland (e.g., size, symmetry, nodularity, tenderness) Seminal vesicles (e.g., symmetry, tenderness, masses, enlargement) Sphincter tone, presence of hemorrhoids, rectal masses
<i>Genitourinary - FEMALE</i>	<p>Includes at least seven of the following eleven elements identified by bullets:</p> <ul style="list-style-type: none"> Inspection and palpation of breasts (e.g., masses or lumps, tenderness, symmetry, nipple discharge) Digital rectal examination including sphincter tone, presence of hemorrhoids, rectal masses <p>Pelvic examination (with or without specimen collection for smears and cultures) including:</p> <ul style="list-style-type: none"> External genitalia (e.g., general appearance, hair distribution, lesions) Urethral meatus (e.g., size, location, lesions, prolapse) Urethra (e.g., masses, tenderness, scarring) Bladder (e.g., fullness, masses, tenderness) Vagina (e.g., general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele, rectocele) Cervix (e.g., general appearance, lesions, discharge) Uterus (e.g., size, contour, position, mobility, tenderness, consistency, descent, or support) Adnexa/parametria (e.g., masses, tenderness, organomegaly, nodularity) Anus and perineum
<i>Lymphatic</i>	<ul style="list-style-type: none"> Palpation of lymph nodes in neck, axillae, groin, and/or other location
<i>Skin</i>	<ul style="list-style-type: none"> Inspection and/or palpation of skin and subcutaneous tissue (e.g., rashes, lesions, ulcers)
<i>Neurological/Psychiatric</i>	<p>Brief assessment of mental status, including</p> <ul style="list-style-type: none"> Orientation (e.g., time, place, and person) Mood and affect (e.g., depression, anxiety, agitation)

CONTENT AND DOCUMENTATION REQUIREMENTS FOR GENITOURINARY EXAMINATION

Level of Examination	Perform and Document
<i>Problem Focused</i>	One to five elements identified by a bullet
<i>Expanded Problem Focused</i>	At least six elements identified by a bullet
<i>Detailed</i>	At least twelve elements identified by a bullet
<i>Comprehensive</i>	Perform all elements identified by a bullet; document every element in each shaded box and at least one element in each unshaded box

HEMATOLOGIC/LYMPHATIC/IMMUNOLOGIC EXAMINATION

System/Body Area	Elements of Examination
<i>Constitutional</i>	<ul style="list-style-type: none"> Measurement of any three of the following seven vital signs: <ol style="list-style-type: none"> sitting or standing blood pressure supine blood pressure pulse rate and regularity respiration temperature height weight (may be measured and recorded by ancillary staff) General appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming)
<i>Head and Face</i>	<ul style="list-style-type: none"> Palpation and/or percussion of face with notation of presence or absence of sinus tenderness
<i>Eyes</i>	<ul style="list-style-type: none"> Inspection of conjunctivae and lids
<i>Ears, Nose, Mouth, and Throat</i>	<ul style="list-style-type: none"> Otoscopic examination of external auditory canals and tympanic membranes Inspection of nasal mucosa, septum, and turbinates Inspection of teeth and gums Examination of oropharynx (e.g., oral mucosa, hard and soft palates, tongue, tonsils, posterior pharynx)
<i>Neck</i>	<ul style="list-style-type: none"> Examination of neck (e.g., masses, overall appearance, symmetry, tracheal position, crepitus) Examination of thyroid (e.g., enlargement, tenderness, mass)
<i>Respiratory</i>	<ul style="list-style-type: none"> Assessment of respiratory effort (e.g., intercostal retractions, use of accessory muscles, diaphragmatic movement) Auscultation of lungs (e.g., breath sounds, adventitious sounds, rubs)
<i>Cardiovascular</i>	<ul style="list-style-type: none"> Auscultation of heart with notation of abnormal sounds and murmurs Examination of peripheral vascular system by observation (e.g., swelling, varicosities) and palpation (e.g., pulses, temperature, edema, tenderness)
<i>Gastrointestinal (abdomen)</i>	<ul style="list-style-type: none"> Examination of abdomen with notation of presence of masses or tenderness Examination of liver and spleen
<i>Lymphatic</i>	<ul style="list-style-type: none"> Palpation of lymph nodes in neck, axillae, groin, and/or other location
<i>Extremities</i>	<ul style="list-style-type: none"> Inspection and palpation of digits and nails (e.g., clubbing, cyanosis, inflammation, petechiae, ischemia, infections, nodes)
<i>Skin</i>	<ul style="list-style-type: none"> Inspection and/or palpation of skin and subcutaneous tissue (e.g., rashes, lesions, ulcers, ecchymoses, bruises)
<i>Neurological/Psychiatric</i>	Brief assessment of mental status, including: <ul style="list-style-type: none"> Orientation to time, place, and person Mood and affect (e.g., depression, anxiety, agitation)

CONTENT AND DOCUMENTATION REQUIREMENTS FOR HEMATOLOGIC/LYMPHATIC/IMMUNOLOGIC EXAMINATION

Level of Examination	Perform and Document
<i>Problem Focused</i>	One to five elements identified by a bullet
<i>Expanded Problem Focused</i>	At least six elements identified by a bullet
<i>Detailed</i>	At least twelve elements identified by a bullet
<i>Comprehensive</i>	Perform all elements identified by a bullet; document every element in each shaded box and at least one element in each unshaded box

MUSCULOSKELETAL EXAMINATION

System/Body Area	Elements of Examination
<i>Constitutional</i>	<ul style="list-style-type: none"> Measurement of any three of the following seven vital signs: <ol style="list-style-type: none"> sitting or standing blood pressure supine blood pressure pulse rate and regularity respiration temperature height weight (may be measured and recorded by ancillary staff) General appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming)
<i>Cardiovascular</i>	<ul style="list-style-type: none"> Examination of peripheral vascular system by observation (e.g., swelling, varicosities) and palpation (e.g., pulses, temperature, edema, tenderness)
<i>Lymphatic</i>	<ul style="list-style-type: none"> Palpation of lymph nodes in neck, axillae, groin, and/or other location
<i>Musculoskeletal</i>	<ul style="list-style-type: none"> Examination of gait and station <p>Examination of joint(s), bone(s) and muscle(s)/ tendon(s) of four of the following six areas:</p> <ol style="list-style-type: none"> head and neck spine, ribs, and pelvis right upper extremity left upper extremity right lower extremity left lower extremity <p>The examination of a given area includes:</p> <ul style="list-style-type: none"> Inspection, percussion and/or palpation with notation of any misalignment, asymmetry, crepitation, defects, tenderness, masses, or effusions Assessment of range of motion with notation of any pain (e.g., straight leg raising), crepitation, or contracture Assessment of stability with notation of any dislocation (luxation), subluxation, or laxity Assessment of muscle strength and tone (e.g., flaccid, cog wheel, spastic) with notation of any atrophy or abnormal movements <p>Note: For the comprehensive level of examination, all four of the elements identified by a bullet must be performed and documented for each of four anatomic areas. For the three lower levels of examination, each element is counted separately for each body area. For example, assessing range of motion in two extremities constitutes two elements.</p>
<i>Extremities</i>	(See musculoskeletal and skin)
<i>Skin</i>	<ul style="list-style-type: none"> Inspection and/or palpation of skin and subcutaneous tissue (e.g., scars, rashes, lesions, café-au-lait spots, ulcers) in four of the following six areas: <ol style="list-style-type: none"> head and neck trunk right upper extremity left upper extremity right lower extremity left lower extremity <p>Note: For the comprehensive level, the examination of all four anatomic areas must be performed and documented. For the three lower levels of examination, each body area is counted separately. For example, inspection and/or palpation of the skin and subcutaneous tissue of two extremities constitute two elements.</p>
<i>Neurological/Psychiatric</i>	<ul style="list-style-type: none"> Test coordination (e.g., finger/nose, heel/ knee/shin, rapid alternating movements in the upper and lower extremities, evaluation of fine motor coordination in young children) Examination of deep tendon reflexes and/or nerve stretch test with notation of pathological reflexes (e.g., Babinski) Examination of sensation (e.g., by touch, pin, vibration, proprioception) <p>Brief assessment of mental status including:</p> <ul style="list-style-type: none"> Orientation to time, place, and person Mood and affect (e.g., depression, anxiety, agitation)

CONTENT AND DOCUMENTATION REQUIREMENTS FOR MUSCULOSKELETAL EXAMINATION

Level of Examination	Perform and Document
<i>Problem Focused</i>	One to five elements identified by a bullet
<i>Expanded Problem Focused</i>	At least six elements identified by a bullet
<i>Detailed</i>	At least twelve elements identified by a bullet
<i>Comprehensive</i>	Perform all elements identified by a bullet; document every element in each shaded box and at least one element in each unshaded box

NEUROLOGICAL EXAMINATION

System/Body Area	Elements of Examination
<i>Constitutional</i>	<ul style="list-style-type: none"> Measurement of any three of the following seven vital signs: <ol style="list-style-type: none"> sitting or standing blood pressure supine blood pressure pulse rate and regularity respiration temperature height weight (may be measured and recorded by ancillary staff) General appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming)
<i>Eyes</i>	<ul style="list-style-type: none"> Ophthalmoscopic examination of optic discs (e.g., size, C/D ratio, appearance) and posterior segments (e.g., vessel changes, exudates, hemorrhages)
<i>Cardiovascular</i>	<ul style="list-style-type: none"> Examination of carotid arteries (e.g., pulse amplitude, bruits) Auscultation of heart with notation of abnormal sounds and murmurs Examination of peripheral vascular system by observation (e.g., swelling, varicosities) and palpation (e.g., pulses, temperature, edema, tenderness)
<i>Musculoskeletal</i>	<ul style="list-style-type: none"> Examination of gait and station Assessment of motor function including: <ul style="list-style-type: none"> Muscle strength in upper and lower extremities Muscle tone in upper and lower extremities (e.g., flaccid, cog wheel, spastic) with notation of any atrophy or abnormal movements (e.g., fasciculation, tardive dyskinesia)
<i>Extremities</i>	(See musculoskeletal)
<i>Neurological</i>	Evaluation of higher integrative functions including: <ul style="list-style-type: none"> Orientation to time, place, and person Recent and remote memory Attention span and concentration Language (e.g., naming objects, repeating phrases, spontaneous speech) Fund of knowledge (e.g., awareness of current events, past history, vocabulary) Test the following cranial nerves: <ul style="list-style-type: none"> 2nd cranial nerve (e.g., visual acuity, visual fields, fundi) 3rd, 4th and 6th cranial nerves (e.g., pupils, eye movements) 5th cranial nerve (e.g., facial sensation, corneal reflexes) 7th cranial nerve (e.g., facial symmetry, strength) 8th cranial nerve (e.g., hearing with tuning fork, whispered voice, and/or finger rub) 9th cranial nerve (e.g., spontaneous or reflex palate movement) 11th cranial nerve (e.g., shoulder shrug strength) 12th cranial nerve (e.g., tongue protrusion) <ul style="list-style-type: none"> Examination of sensation (e.g., by touch, pin, vibration, proprioception) Examination of deep tendon reflexes in upper and lower extremities with notation of pathological reflexes (e.g., Babinski) Test coordination (e.g., finger/nose, heel/knee/shin, rapid alternating movements in the upper and lower extremities, evaluation of fine motor coordination in young children)

CONTENT AND DOCUMENTATION REQUIREMENTS FOR NEUROLOGICAL EXAMINATION

Level of Examination	Perform and Document
<i>Problem Focused</i>	One to five elements identified by a bullet
<i>Expanded Problem Focused</i>	At least six elements identified by a bullet
<i>Detailed</i>	At least twelve elements identified by a bullet
<i>Comprehensive</i>	Perform all elements identified by a bullet; document every element in each shaded box and at least one element in each unshaded box

PSYCHIATRIC EXAMINATION

System/Body Area	Elements of Examination
<i>Constitutional</i>	<ul style="list-style-type: none"> • Measurement of any three of the following seven vital signs: <ol style="list-style-type: none"> 1. sitting or standing blood pressure 2. supine blood pressure 3. pulse rate and regularity 4. respiration 5. temperature 6. height 7. weight (may be measured and recorded by ancillary staff) • General appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming)
<i>Musculoskeletal</i>	<ul style="list-style-type: none"> • Assessment of muscle strength and tone (e.g., flaccid, cog wheel, spastic) with notation of any atrophy and abnormal movements • Examination of gait and station
<i>Psychiatric</i>	<ul style="list-style-type: none"> • Description of speech including: rate; volume; articulation; coherence; and spontaneity with notation of abnormalities (e.g., perseveration, paucity of language) • Description of thought processes including: rate of thoughts; content of thoughts (e.g., logical vs. illogical, tangential); abstract reasoning; and computation • Description of associations (e.g., loose, tangential, circumstantial, intact) • Description of abnormal or psychotic thoughts including: hallucinations; delusions; pre-occupation with violence; homicidal or suicidal ideation; and obsessions • Description of the patient's judgment (e.g., concerning everyday activities and social situations) and insight (e.g., concerning psychiatric condition) <p>Complete mental status examination including:</p> <ul style="list-style-type: none"> • Orientation to time, place, and person • Recent and remote memory • Attention span and concentration • Language (e.g., naming objects, repeating phrases) • Fund of knowledge (e.g., awareness of current events, past history, vocabulary) • Mood and affect (e.g., depression, anxiety, agitation, hypomania, lability)

CONTENT AND DOCUMENTATION REQUIREMENTS FOR PSYCHIATRIC EXAMINATION

Level of Examination	Perform and Document
<i>Problem Focused</i>	One to five elements identified by a bullet
<i>Expanded Problem Focused</i>	At least six elements identified by a bullet
<i>Detailed</i>	At least nine elements identified by a bullet
<i>Comprehensive</i>	Perform all elements identified by a bullet; document every element in each shaded box and at least one element in each unshaded box

RESPIRATORY EXAMINATION

System/Body Area	Elements of Examination
<i>Constitutional</i>	<ul style="list-style-type: none"> • Measurement of any three of the following seven vital signs: <ol style="list-style-type: none"> 1. sitting or standing blood pressure 2. supine blood pressure 3. pulse rate and regularity 4. respiration 5. temperature 6. height 7. weight (may be measured and recorded by ancillary staff) • General appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming)
<i>Ears, Nose, Mouth, and Throat</i>	<ul style="list-style-type: none"> • Inspection of nasal mucosa, septum, and turbinates • Inspection of teeth and gums • Examination of oropharynx (e.g., oral mucosa, hard and soft palates, tongue, tonsils, and posterior pharynx)
<i>Neck</i>	<ul style="list-style-type: none"> • Examination of neck (e.g., masses, overall appearance, symmetry, tracheal position, crepitus) • Examination of thyroid (e.g., enlargement, tenderness, mass) • Examination of jugular veins (e.g., distension; a, v, or cannon a waves)
<i>Respiratory</i>	<ul style="list-style-type: none"> • Inspection of chest with notation of symmetry and expansion • Assessment of respiratory effort (e.g., intercostal retractions, use of accessory muscles, diaphragmatic movement) • Percussion of chest (e.g., dullness, flatness, hyperresonance) • Palpation of chest (e.g., tactile fremitus) • Auscultation of lungs (e.g., breath sounds, adventitious sounds, rubs)
<i>Cardiovascular</i>	<ul style="list-style-type: none"> • Auscultation of heart including sounds, abnormal sounds and murmurs • Examination of peripheral vascular system by observation (e.g., swelling, varicosities) and palpation (e.g., pulses, temperature, edema, tenderness)
<i>Gastrointestinal (abdomen)</i>	<ul style="list-style-type: none"> • Examination of abdomen with notation of presence of masses or tenderness • Examination of liver and spleen
<i>Lymphatic</i>	<ul style="list-style-type: none"> • Palpation of lymph nodes in neck, axillae, groin and/or other location
<i>Musculoskeletal</i>	<ul style="list-style-type: none"> • Assessment of muscle strength and tone (e.g., flaccid, cog wheel, spastic) with notation of any atrophy and abnormal movements • Examination of gait and station
<i>Extremities</i>	<ul style="list-style-type: none"> • Inspection and palpation of digits and nails (e.g., clubbing, cyanosis, inflammation, petechiae, ischemia, infections, nodes)
<i>Skin</i>	<ul style="list-style-type: none"> • Inspection and/or palpation of skin and subcutaneous tissue (e.g., rashes, lesions, ulcers)
<i>Neurological/Psychiatric</i>	Brief assessment of mental status including: <ul style="list-style-type: none"> • Orientation to time, place, and person • Mood and affect (e.g., depression, anxiety, agitation)

CONTENT AND DOCUMENTATION REQUIREMENTS FOR RESPIRATORY EXAMINATION

Level of Examination	Perform and Document
<i>Problem Focused</i>	One to five elements identified by a bullet
<i>Expanded Problem Focused</i>	At least six elements identified by a bullet
<i>Detailed</i>	At least twelve elements identified by a bullet
<i>Comprehensive</i>	Perform all elements identified by a bullet; document every element in each shaded box and at least one element in each unshaded box

SKIN EXAMINATION

System/Body Area	Elements of Examination
<i>Constitutional</i>	<ul style="list-style-type: none"> Measurement of any three of the following seven vital signs: <ol style="list-style-type: none"> sitting or standing blood pressure supine blood pressure pulse rate and regularity respiration temperature height weight (may be measured and recorded by ancillary staff) General appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming)
<i>Eyes</i>	<ul style="list-style-type: none"> Inspection of conjunctivae and lids
<i>Ears, Nose, Mouth and Throat</i>	<ul style="list-style-type: none"> Inspection of lips, teeth, and gums Examination of oropharynx (e.g., oral mucosa, hard and soft palates, tongue, tonsils, posterior pharynx)
<i>Neck</i>	<ul style="list-style-type: none"> Examination of thyroid (e.g., enlargement, tenderness, mass)
<i>Cardiovascular</i>	<ul style="list-style-type: none"> Examination of peripheral vascular system by observation (e.g., swelling, varicosities) and palpation (e.g., pulses, temperature, edema, tenderness)
<i>Gastrointestinal (abdomen)</i>	<ul style="list-style-type: none"> Examination of liver and spleen Examination of anus for condyloma and other lesions
<i>Lymphatic</i>	<ul style="list-style-type: none"> Palpation of lymph nodes in neck, axillae, groin, and/or other location
<i>Extremities</i>	<ul style="list-style-type: none"> Inspection and palpation of digits and nails (e.g., clubbing, cyanosis, inflammation, petechiae, ischemia, infections, nodes)
<i>Skin</i>	<ul style="list-style-type: none"> Palpation of scalp and inspection of hair of scalp, eyebrows, face, chest, pubic area, (when indicated) and extremities Inspection and/or palpation of skin and subcutaneous tissue (e.g., rashes, lesions, ulcers, susceptibility to and presence of photo damage) in eight of the following ten areas: <ul style="list-style-type: none"> Head, including the face Neck Chest, including breasts and axillae Abdomen Genitalia, groin, buttocks Back Right upper extremity Left upper extremity Right lower extremity Left lower extremity <p>Note: For the comprehensive level, the examination of at least eight anatomic areas must be performed and documented. For the three lower levels of examination, each body area is counted separately. For example, inspection and/or palpation of the skin and subcutaneous tissue of the right upper extremity and the left upper extremity constitute two elements.</p> <ul style="list-style-type: none"> Inspection of eccrine and apocrine glands of skin and subcutaneous tissue with identification and location of any hyperhidrosis, chromhidroses, or bromhidrosis
<i>Neurological/Psychiatric</i>	<p>Brief assessment of mental status including:</p> <ul style="list-style-type: none"> Orientation to time, place, and person Mood and affect (e.g., depression, anxiety, agitation)

CONTENT AND DOCUMENTATION REQUIREMENTS FOR SKIN EXAMINATION

Level of Examination	Perform and Document
<i>Problem Focused</i>	One to five elements identified by a bullet
<i>Expanded Problem Focused</i>	At least six elements identified by a bullet
<i>Detailed</i>	At least twelve elements identified by a bullet
<i>Comprehensive</i>	Perform all elements identified by a bullet; document every element in each shaded box and at least one element in each unshaded box

C. DOCUMENTING THE COMPLEXITY OF MEDICAL DECISION MAKING

The levels of E/M services recognize four levels of medical decision making:

- Straightforward
- Low complexity
- Moderate complexity
- High complexity

Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by the:

- Number of possible diagnoses and/or the number of management options that must be considered;
- Amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed; and
- Risk of significant complications, morbidity and/or mortality, as well as co-morbidities, associated with the patient's presenting problem(s), the diagnostic procedure(s), and/or the possible management options.

The table below shows the progression of the elements required for each level of medical decision making. To qualify for a given type of decision making, **two of the three elements in the table must be either met or exceeded.**

Number of diagnoses or management options	Amount and/or complexity of data to be reviewed	Risk of complications and/or morbidity or mortality	Type of medical decision making
Minimal	Minimal or None	Minimal	<i>Straightforward</i>
Limited	Limited	Low	<i>Low Complexity</i>
Multiple	Moderate	Moderate	<i>Moderate Complexity</i>
Extensive	Extensive	High	<i>High Complexity</i>

The following sections describe each of the elements of medical decision making.

NUMBER OF DIAGNOSES OR MANAGEMENT OPTIONS

The number of possible diagnoses and/or the number of management options that must be considered is based on the number and types of problems addressed during the encounter, the complexity of establishing a diagnosis, and the management decisions that are made by the physician.

Generally, decision making with respect to a diagnosed problem is easier than that for an identified but undiagnosed problem. The number and type of diagnostic tests employed may be an indicator of the number of possible diagnoses. Problems that are improving or resolving are less complex than those that are worsening or failing to change as expected. The need to seek advice from others is another indicator of complexity of diagnostic or management problems.

- **DG:** *For each encounter, an assessment, clinical impression, or diagnosis should be documented. It may be explicitly stated or implied in documented decisions regarding management plans and/or further evaluation.*

- *For a presenting problem with an established diagnosis, the record should reflect whether the problem is: a) improved, well controlled, resolving, or resolved; or, b) inadequately controlled, worsening, or failing to change as expected.*
 - *For a presenting problem without an established diagnosis, the assessment or clinical impression may be stated in the form of differential diagnoses or as a “possible,” “probable,” or “rule out” (R/O) diagnosis.*
- DG:** *The initiation of, or changes in, treatment should be documented. Treatment includes a wide range of management options including patient instructions, nursing instructions, therapies, and medications.*
- DG:** *If referrals are made, consultations requested, or advice sought, the record should indicate to whom or where the referral or consultation is made or from whom the advice is requested.*

AMOUNT AND/OR COMPLEXITY OF DATA TO BE REVIEWED

The amount and complexity of data to be reviewed is based on the types of diagnostic testing ordered or reviewed. A decision to obtain and review old medical records and/or obtain history from sources other than the patient increases the amount and complexity of data to be reviewed.

Discussion of contradictory or unexpected test results with the physician who performed or interpreted the test is an indication of the complexity of data being reviewed. On occasion the physician who ordered a test may personally review the image, tracing or specimen to supplement information from the physician who prepared the test report or interpretation; this is another indication of the complexity of data being reviewed.

- DG:** *If a diagnostic service (test or procedure) is ordered, planned, scheduled, or performed at the time of the E/M encounter, the type of service, e.g., lab or X-ray, should be documented.*
- DG:** *The review of lab, radiology, and/or other diagnostic tests should be documented. A simple notation such as “WBC elevated” or “chest X-ray unremarkable” is acceptable. Alternatively, the review may be documented by initialing and dating the report containing the test results.*
- DG:** *A decision to obtain old records or decision to obtain additional history from the family, caretaker, or other source to supplement that obtained from the patient should be documented.*
- DG:** *Relevant findings from the review of old records, and/or the receipt of additional history from the family, caretaker, or other source to supplement that obtained from the patient should be documented. If there is no relevant information beyond that already obtained, that fact should be documented. A notation of “old records reviewed” or “additional history obtained from family” without elaboration is insufficient.*
- DG:** *The results of discussion of laboratory, radiology, or other diagnostic tests with the physician who performed or interpreted the study should be documented.*
- DG:** *The direct visualization and independent interpretation of an image, tracing, or specimen previously or subsequently interpreted by another physician should be documented.*

RISK OF SIGNIFICANT COMPLICATIONS, MORBIDITY, AND/OR MORTALITY

The risk of significant complications, morbidity, and/or mortality is based on the risks associated with the presenting problem(s), the diagnostic procedure(s), and the possible management options.

- DG:** *Co-morbidities/underlying diseases or other factors that increase the complexity of medical decision making by increasing the risk of complications, morbidity, and/or mortality should be documented.*
- DG:** *If a surgical or invasive diagnostic procedure is ordered, planned, or scheduled at the time of the E/M encounter, the type of procedure, (e.g., laparoscopy), should be documented.*
- DG:** *If a surgical or invasive diagnostic procedure is performed at the time of the E/M encounter, the specific procedure should be documented.*
- DG:** *The referral for or decision to perform a surgical or invasive diagnostic procedure on an urgent basis should be documented or implied.*

The Table of Risk on the following page may be used to help determine whether the risk of significant complications, morbidity, and/or mortality is *minimal, low, moderate, or high*. Because the determination of risk is complex and not readily quantifiable, the table includes common clinical examples rather than absolute measures of risk. The assessment of risk of the presenting problem(s) is based on the risk related to the disease process anticipated between the present encounter and the next one. The assessment of risk of selecting diagnostic procedures and management options is based on the risk during and immediately following any procedures or treatment. **The highest level of risk in any one category—presenting problem(s), diagnostic procedure(s), or management option(s)—determines the overall risk.**

TABLE OF RISK

Level of Risk	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options Selected
<i>Minimal</i>	<ul style="list-style-type: none"> One self-limited or minor problem (e.g., cold, insect bite, tinea corporis) 	<ul style="list-style-type: none"> Laboratory tests requiring venipuncture Chest X-rays EKG/EEG Urinalysis Ultrasound (e.g., echocardiography) KOH prep 	<ul style="list-style-type: none"> Rest Gargles Elastic bandages Superficial dressings
<i>Low</i>	<ul style="list-style-type: none"> Two or more self-limited or minor problems One stable chronic illness (e.g., well controlled hypertension, noninsulin dependent diabetes, cataract, BPH) Acute uncomplicated illness or injury (e.g., cystitis, allergic rhinitis, simple sprain) 	<ul style="list-style-type: none"> Physiologic tests not under stress (e.g., pulmonary function tests) Noncardiovascular imaging studies with contrast (e.g., barium enema) Superficial needle biopsies Clinical laboratory tests requiring arterial puncture Skin biopsies 	<ul style="list-style-type: none"> Over-the-counter drugs Minor surgery with no identified risk factors Physical therapy Occupational therapy IV fluids without additives
<i>Moderate</i>	<ul style="list-style-type: none"> One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment Two or more stable chronic illnesses Undiagnosed new problem with uncertain prognosis (e.g., lump in breast) Acute illness with systemic symptoms (e.g., pyelonephritis, pneumonitis, colitis) Acute complicated injury (e.g., head injury with brief loss of consciousness) 	<ul style="list-style-type: none"> Physiologic tests under stress (e.g., cardiac stress test, fetal contraction stress test) Diagnostic endoscopies with no identified risk factors Deep needle or incisional biopsy Cardiovascular imaging studies with contrast and no identified risk factors (e.g., arteriogram, cardiac catheterization) Obtain fluid from body cavity (e.g. lumbar puncture, thoracentesis, culdocentesis) 	<ul style="list-style-type: none"> Minor surgery with identified risk factors Elective major surgery (open, percutaneous, or endoscopic) with no identified risk factors Prescription drug management Therapeutic nuclear medicine IV fluids with additives Closed treatment of fracture or dislocation without manipulation
<i>High</i>	<ul style="list-style-type: none"> One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment Acute or chronic illnesses or injuries that pose a threat to life or bodily function (e.g., multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure) An abrupt change in neurologic status (e.g., seizure, TIA, weakness, sensory loss) 	<ul style="list-style-type: none"> Cardiovascular imaging studies with contrast with identified risk factors Cardiac electrophysiological tests Diagnostic endoscopies with identified risk factors Discography 	<ul style="list-style-type: none"> Elective major surgery (open, percutaneous, or endoscopic) with identified risk factors Emergency major surgery (open, percutaneous, or endoscopic) Parenteral controlled substances Drug therapy requiring intensive monitoring for toxicity Decision not to resuscitate or to de-escalate care because of poor prognosis

D. DOCUMENTATION OF AN ENCOUNTER DOMINATED BY COUNSELING OR COORDINATION OF CARE

In the case where counseling and/or coordination of care dominates (more than 50%) of the physician/patient and/or family encounter (face-to-face time in the office or other outpatient setting, floor/unit time in the hospital or nursing facility), time is considered the key or controlling factor to qualify for a particular level of E/M services.

- **DG:** *If the physician elects to report the level of service based on counseling and/or coordination of care, the total length of time of the encounter (face-to-face or floor time, as appropriate) should be documented and the record should describe the counseling and/or activities to coordinate care.*

PROGRESSION OF LEVELS

Progression of Elements Required for Each Level of Medical Decision Making

(two of the three elements in the table must be either met or exceeded)

Number of Diagnoses or Management Options	Amount And/Or Complexity of Data to be Reviewed	Risk of Complications And/Or Morbidity or Mortality	Type of Decision Making
Minimal	Minimal or none	Minimal	<i>Straightforward</i>
Limited	Limited	Low	<i>Low complexity</i>
Multiple	Moderate	Moderate	<i>Moderate complexity</i>
Extensive	Extensive	High	<i>High complexity</i>

EXAMPLES

The following tables reflect an initial and an established office encounter. Use the information provided in this chapter to select the appropriate level of coding for the following three key components of the service:

- *History* — Expanded problem focused
- *Examination* — Detailed
- *Medical decision making* — Moderate complexity

INITIAL PATIENT — OFFICE OR OTHER OUTPATIENT VISIT

(3 of 3 elements must be met or exceeded)

Level	History	Examination	Medical Decision Making
<i>I</i>	Problem focused	Problem focused	<i>Straightforward</i>
<i>II</i>	Expanded problem focused	Expanded problem focused	<i>Straightforward</i>
<i>III</i>	Detailed	Detailed	<i>Low complexity</i>
<i>IV</i>	Comprehensive	Comprehensive	<i>Moderate complexity</i>
<i>V</i>	Comprehensive	Comprehensive	<i>High complexity</i>

LEVEL II is the correct selection. All three key components must be met or exceeded to select a given level.

The following is an example of an established patient encounter using the following three key components:

- History — Problem focused
- Examination — Expanded problem focused
- Medical decision making — Moderate complexity

ESTABLISHED PATIENT — OFFICE OR OTHER OUTPATIENT CONSULTATION

(2 of 3 elements must be met or exceeded)

Level	History	Examination	Medical Decision Making
<i>I</i>	N/A	N/A	<i>N/A</i>
<i>II</i>	Problem focused	Problem focused	<i>Straightforward</i>
<i>III</i>	Expanded problem focused	Expanded problem focused	<i>Low complexity</i>
<i>IV</i>	Detailed	Detailed	<i>Moderate complexity</i>
<i>V</i>	Comprehensive	Comprehensive	<i>High complexity</i>

LEVEL III is the correct selection. Only two of the three key components must be met or exceeded.

Chapter 7 - MEDICAL REVIEW

This chapter discusses the process used by Medicare contractors to identify and prevent inappropriate billing. It explains how Medicare contractors use data to identify inappropriate billing and how they develop medical review (MR) interventions to correct the problem.

Overview

All Medicare contractors are required to ensure that reimbursement is made only for those services that are reasonable and necessary. To ensure that payment is made only for reasonable and necessary services, each Medicare contractor is required to perform extensive analysis of data to identify aberrant billing. Contractors must verify that billing problems exist through the use of limited scope “probe” reviews before taking any corrective action. Further, corrective actions must include educating providers, and must be commensurate with the scope of the verified error. For instance, an error affecting a limited number of claims will result in an educational intervention; whereas, an error affecting a large number of claims will result in an educational intervention combined with added medical review.

Mission and Objectives of the Medical Review Process

The mission of the medical review process is to reduce the claim payment error rate. The educational processes provided by Medicare ensure that a physician knows what to expect when a claim is submitted to the program.

The specific objectives of the medical review process include:

- Identification and prevention of inappropriate Medicare payments
- Utilization of national and local data, to assure only those areas that present the most risk to the program, are subjected to medical review
- Increasing effectiveness of newly developed Local Medical Review Policies (LMRPs)
- Education of physicians on appropriate billing practices
- Ensuring the appropriate reimbursement of Medicare-covered services

Benefits to Medicare Physicians

Medical review initiatives are designed to apply national payment criteria, to define Medicare coverage of medical care through the development of medical policy, and to ensure that LMRPs and review guidelines are consistent with accepted standards of medical practice. The medical review process provides the following benefits:

- *Decreased denials.* Knowledge of appropriate claims guidelines may result in a reduction in filing errors and an increase in more timely payments.
- *Improvement in the way Medicare reviews cases.* Development of LMRPs provide guidelines for the decision making process.
- *Reduced claim reviews.* Because physicians have a better understanding of when and what Medicare needs to support a service as it relates to claim documentation, the claim filing process is smoother and faster.

- *Predictability in claim decisions.* Because local contractor policies are made available to all eligible physicians through contractor publications and Web sites, there is less “guess work” on the behalf of the physician when furnishing information to support medical necessity.
- *Emphasis on education.* Medicare offers educational opportunities through comprehensive articles and contractor-sponsored educational training events.
- *Increased program integrity.* The Medicare Integrity Program, established in 1996, ensures that Medicare pays claims correctly.

Progressive Corrective Action (PCA)

What It Is

Medical Review PCA is a concept designed by the Centers for Medicare & Medicaid Services (CMS) for Medicare contractors to use when deploying resources and tools to conduct medical reviews. PCA ensures that medical review activities are targeted at identified problem areas and that corrective actions imposed are appropriate for the severity of the infraction of Medicare rules and regulations. There are four types of corrective actions that may result from medical review evaluations: education, policy development, prepayment review, and postpayment review.

How It Works

The decision to conduct medical review is driven by data analysis. Data analysis is the starting point for contractors to determine unusual or unexpected billing patterns that might suggest improper billing or payment. The data analysis may be general surveillance, or may be specific in response to complaints or reports from various agencies.

Validating the hypothesis of the data analysis is the next step. Before assigning significant resources to examine claims identified as potential problems, probe reviews are conducted. A probe review generally does not exceed 20-40 claims per physician for physician-specific problems, and does not exceed 100 claims distributed among the identified physician community for general, widespread problems. All physicians subject to a probe review are notified in writing that a probe review is being conducted, and are also notified in writing of review results. Physicians or facilities are asked to provide any and all medical documentation applicable to the claims in question.

What It Accomplishes

Once a probe review validates that an error exists, the contractors classify the severity of the error. Errors are classified as minor, moderate, or major. Physician-specific error rate (number of claims paid in error), dollar amounts improperly paid, and past billing history are examples of items used to determine classification level.

If a minor problem is detected, the Medicare contractor will educate the physician on appropriate billing procedures, will collect the money on claims paid in error, and will conduct further analysis at a later date to ensure the problem was corrected.

If a moderate problem is detected, the contractor will educate the physician on appropriate billing procedures, will collect the money on claims paid in error, and will initiate some level of medical review until the physician has demonstrated correction of his or her billing procedures.

If a major problem is detected, the contractor will educate the physician on appropriate billing procedures, will collect the money on claims paid in error, will initiate a high level of prepayment medical review and/or a statistically valid random sample, suspend payments, and/or refer the case to the contractor's Benefit Integrity department (if and when appropriate).

Physician Education and Feedback

Along with the planned medical review activities, physician feedback and education regarding the review findings is an essential part of all corrective actions. When individual reviews are conducted, focused physician education is provided. This means direct contact between the Medicare contractor and the physician through telephone contact, letter and/or face-to-face meeting. The overall goal of providing feedback and education is to ensure proper billing practices so claims will be submitted and paid correctly.

Types of Corrective Action

Local Medical Review Policy (LMRP) Development

Medical review decisions are made in accordance with both national and local policies. These policies are the foundation of the review process. LMRP is a formal statement developed through a specific process that:

- Defines the service
- Provides information about when a service is considered reasonable and necessary
- Outlines any coverage criteria and/or specific documentation requirements
- Provides specific coding and/or modifier information
- Provides references upon which the policy is based

Once developed and implemented, LMRPs provide the decision-making criteria for claim review and payment decisions. LMRPs are developed using input provided through an advisory committee of medical professionals both within the Medicare Program and the medical community. This process also allows for other medical professionals throughout the state to comment on proposed policies prior to finalization, thus assuring an objective review of the policy.

LMRPs are developed through the following process:

- Carriers develop LMRP in response to:
 1. The absence of a national policy
 2. The need to apply a national (CMS) policy
 3. The advent of new technology
 4. Data analysis indicating the need for LMRP
- Draft LMRP is presented and reviewed at meetings by the Carrier Advisory Committee (CAC), which is a committee of beneficiaries, physicians who have been nominated by their respective specialty associations, the carrier's medical director, and other staff representatives of Medicare.
- Draft LMRPs are available on the carrier's Web site. The physician community has an opportunity to provide input to the contractor's Medical Policy Department regarding the drafted LMRP.
- Draft LMRPs are published and after a 45-day comment period, Carriers review comments and develop the final LMRP.
- Final LMRP is published on the carriers' Web site, at www.lmrp.net on the Internet, and is available in hardcopy by request.
- Implementation occurs at least 30 days after physician notification

Physicians are responsible for reading and knowing the information in LMRP. Physicians should keep and use LMRPs as ongoing references and instructional guides when billing Medicare. If the contractor can determine that the physician knew, or should have known, the proper way to bill or utilize coding techniques, etc., the improper billing may be determined to be a willful or fraudulent act.

Edit Development

Contractors develop “edits” in the claims processing system in order to select claims for review, apply medical review logic, and screen claims for possible aberrancy. Edits can take the following forms.

Prepayment Edits

Prepayment edits are designed by contractor staff and put in place to prevent payment for noncovered and/or incorrectly coded services and to select targeted claims for review prior to payment. MR edit development is the creation of logic (the edit) that is used during claim processing prior to payment that validates and/or compares data elements on the claim.

Service Specific Edits

These are edits that select claims containing specific services for review. They may compare two or more data elements present on the same claim (e.g., diagnosis to procedure code), or they may compare one or more data elements on a claim with data from the beneficiary’s history file (e.g., procedure code compared to history file to determine frequency in past 12 months).

Provider Specific Edits

These are edits that select claims from specific providers flagged for review. These providers are selected due to unusual practice patterns, knowledge of service area abuses, and/or utilization complaints received from beneficiaries or others. These edits may suspend all claims from a particular provider or focus on claims for selected services, place of service, etc. from a selected provider.

Prepayment Review

Prepayment review consists of medical review of a claim prior to payment. This type of review may require submission of medical records and includes automated, routine, and complex activities. Prepayment review may affect any physician.

Automated Prepayment Review

When prepayment review is automated, decisions are made at the system level, using available electronic information, without the intervention of contractor personnel. Automated editing allows the contractor to review information submitted on the claim regarding particular procedure codes. This may consist of the following:

- Diagnosis to procedure code
- Frequency to time
- Place of service to procedure code
- Specialty to procedure code

Routine Prepayment Review

Routine prepayment review is limited to rule-based determinations performed by specially trained MR staff. An intervention can occur at any point in the review process. For example, a claim may be

suspended for routine review because an MR determination cannot be automated. Routine review requires hands-on review of the claim and/or any attachment submitted by the provider (other than medical records) and/or claims history file and/or internal MR guidelines.

Complex Prepayment Review

Complex medical review involves evaluating medical records or other documentation, by a licensed medical professional. Complex medical review determinations require the reviewer to make a judgment about whether a service is covered and is reasonable and necessary. Nurses (RN/LPN) or physicians must conduct this type of review, unless delegated to other licensed healthcare professionals. If delegated, other healthcare professionals may only review services within their scope of practice and expertise (e.g., speech therapy, physical therapy).

Provider Specific Review

A provider specific review may include certain procedures performed by a particular provider or all claims from a particular physician and requires documentation submission, and results in either an educational intervention by the contractor or further corrective actions. Physicians are notified that documentation submission is required. Contractors will only review claims for procedure codes where aberrant billing is suspected.

Postpayment Review

Postpayment review involves medical review of a claim after payment has been made. This type of review often requires submission of medical records and includes both routine and complex review activities. Postpayment medical review may affect any physician.

Provider Specific Postpayment Probe Review

When an individual physician is identified as being statistically different from their peers, a probe review is conducted. A small number of claims (20-40) are identified and a letter is sent to the physician requesting medical documentation to support those claims. Once the documentation is received, it is reviewed to determine if the claims were documented as having been performed, coded correctly, reasonable and necessary, and a covered Medicare benefit. The physician will be notified in writing of the results of the review. The next steps in the process are dependent upon the results of the review and may include physician education, collection of money paid in error, continued medical review, or a review of a statistically valid random sample (SVRS) of provider claims.

Widespread Probe Review

If a widespread problem is identified, approximately 100 claims are reviewed. An example of such a problem would be an overall spike in billing for a procedure or diagnosis code. A few claims (5-10) will be requested from several individual physicians who have been billing the code in question. The results of this review will determine whether: 1.) widespread physician education is appropriate, 2.) money paid in error needs to be collected, 3.) a policy needs to be developed, 4.) an existing policy needs to be revised, or 5.) system prepayment edits or audits need to be implemented.

Statistically Valid Random Sample (SVRS)

SVRS is an in-depth audit of a physician's utilization, coding, and documentation practices. It is used after problems with a physician's utilization pattern have been validated through a probe review and only when the validated problem is of the most extreme scope. This type of review will result in one or more of the following actions: physician education, overpayment request (possibly projected to the universe of claims submitted by that physician), or prepayment medical review. If continued

noncompliance is demonstrated, despite documented educational interventions, a referral may be made to the Benefit Integrity department for investigation and possible suspension.

Proactive Measures Related to Local Medical Review Policy

General

The purpose of the Medical Review process is to ensure that claims are paid correctly. The following are some measures physicians can take to help avoid any negative impact associated with the Medical Review process:

- Review and read all carrier physician publications and LMRPs and become knowledgeable about the coverage requirements
- Ensure that office staff and billing vendors are familiar with claim filing rules associated with any LMRP
- Check records against claims billed
- Create an educational awareness campaign for Medicare patients that helps them understand any specific coverage limitations or medical necessity requirements for those services provided
- Work with claim submission vendors to incorporate LMRP edits
- Perform mock record audits to ensure that documentation reflects the requirements outlined in the LMRP

Documentation

In order for the contractors to perform an effective medical review of services, it may be necessary for the physician to furnish documentation to support the services being reviewed. The following points about submitting documentation should be kept in mind:

- Every service billed must be documented. There must be clear evidence in the patient's record that the service, procedure, or supply was actually performed or supplied.
- The medical necessity for choosing the procedure, service, or medical supply must be substantiated.
- Every service must be coded correctly. Diagnoses must be coded to the highest level of specificity, and procedure codes must be current.
- The documentation must clearly indicate who performed the procedure or supplied the equipment.
- Although it may be dictated and transcribed, legible documentation is required. Existing documentation may not be embellished (e.g., adding what was omitted in the initial documentation); however, additional documentation that supports a claim may be submitted.
- Voluntary disclosure of information by the physician is encouraged. When an error is discovered, it is always preferable to return any overpayments to Medicare.

Occasionally, documentation is requested through the contractor's Additional Development Request (ADR) letter. The Contractor may request documentation either during a data driven review or when the physician contests a denial determination (by requesting a review of the claim). Examples of documentation needed for medical review of physician services could include, but are not limited to:

- Office records including progress notes, a current history and physical, and a treatment plan
- Documentation of the identity and professional status of the physician
- Laboratory and radiology reports
- A comprehensive problem list
- A current list of prescribed medications
- Progress notes for each visit that demonstrates the patient's response to prescribed treatment

Chapter 8 - INQUIRY, APPEAL, WAIVER, AND OVERPAYMENT

This chapter discusses ways to get claims information and appeal claim denials. Medicare offers several options to assist physicians, suppliers, and others who work with the Part B Program.

Inquiry

Inquiries are requests for information about claims or coverage and reimbursement guidelines. An inquiry may be made to the local Medicare carrier by telephone or in writing.

Customer Service Representatives (CSR)

Medicare contractor CSRs are available to answer questions and assist with inquiries and can help with most billing issues. The toll-free telephone numbers for most contractors are available at www.cms.hhs.gov/medlearn/tollnums.asp on the Internet.

Automated Response System (ARS)

Some Medicare carrier sites have an ARS that provides physicians with information usually provided by CSRs.

Information available through the ARS may include:

- Claim status (complete information on assigned claims, limited status on nonassigned claims, and denial information)
- Number of pending and finalized claims
- Date and check number of physician's most recent check
- Year-to-date dollar amount paid to physician
- Educational messages about hot topics

The ARS is usually accessible 24 hours a day. There is usually no limit on the length of time or number of requests and responses per call. Time is saved because the user can "speed dial" through information menus.

Note: The local Medicare contractor can furnish physicians with specific information regarding ARS.

Appealing Medicare Decisions

There are several levels in the appeals process. Each level of appeal is described in detail in the subsequent sections. Once an initial claim determination (sometimes referred to as an "initial determination") has been made, physicians may have appeal rights depending upon, in most instances, whether the claim is assigned or unassigned. Each level, after the initial determination, has procedural steps that must be followed by the appellant before an appeal may proceed to the next level. The appellant may exercise his or her right to appeal any determination/decision to the next higher level until all appeal rights are exhausted. Although there are five distinct levels in the appeals process, the Hearing Officer (HO) hearing, level two, is the last level in the appeals process performed by the carrier.

Assigned Claims

- The physician may request a review of an assigned claim.

Nonassigned Claims

- Typically, only the patient or the patient's representative can request a review of a nonassigned claim. However, a physician may request a review only if services were denied or reduced, based on medical necessity guidelines, and the physician is liable for the denial or reduction. The physician may also request a review of a nonassigned claim if the beneficiary authorizes it in writing. The review request must include the beneficiary's signed authorization.

Review – 1st Level of Appeal

The first level of appeal is called a review. A review is an independent, critical examination of a claim made by carrier personnel not involved in the initial claim determination. A request for a review may be made to the local Medicare carrier by telephone or in writing. Physicians may request a review. The appellant (an individual who appeals a claim decision) must begin the appeals process at the first level after receiving an initial claim determination. The appellant has 120 days from the date of the initial claim determination to file an appeal.

Certain claim denials may be resubmitted with corrected information without requesting a review. For example:

- Claims denied due to insufficient information
- Claims returned as “unprocessable” due to incomplete or incorrect information
- Claims where the diagnosis was not coded to the highest level of specificity

Requesting a Review in Writing

A request for a review can be filed on Form CMS-1964 (available electronically at www.cms.hhs.gov/forms on the Internet) or in any other format that includes the following information:

- Beneficiary name;
- Medicare health insurance claim (HIC) number;
- Name and address of provider/supplier of item/service;
- Date of initial determination;
- Date(s) of service for which the initial determination was issued;
- Which item(s), if any, and/or service(s) are at issue in the appeal; and
- Signature of the appellant.

When requesting a review in writing, the appellant should attach any supporting documentation.

Requesting a Review by Telephone

Requests for review of claim denials may be made by telephone. When requesting a review by telephone, the appellant should be prepared with the following information: beneficiary name; beneficiary date of birth, Medicare health insurance (HIC) number; name and address of physician/supplier of item/service; date of initial determination; date of service for which the initial determination was issued, which item(s) if any, and/or service(s) are at issue in the appeal. For more information about this process, contact the Customer Service toll-free inquiries line of the local Medicare contractor.

Please note that when a review is requested by telephone, this does not ensure that the request will be resolved during the telephone call. Some claim denials are typically resolved after the telephone re-

quest through a written process. If this happens, the appellant will be notified of the results of his/her request through a written decision letter or through a Remittance Advice (RA).

Examples of issues that are typically not resolved over the telephone include:

- Utilization limit denials
- Services denied because the diagnosis did not warrant the procedure, and the correct diagnosis was initially submitted on the claim form

When a review is requested, medical documentation justifying the procedure may be needed. The local carrier informs the physician of the specific documentation needed to conduct the review.

Review Decision Notification

When the review request is received, a written response, which varies with the action taken, will be sent:

- If the original claim decision is upheld, a detailed letter will be sent explaining why additional payment cannot be allowed.
- If the original claim decision can be changed and payment is due, a new beneficiary notice and check will be issued.
- If the original claim decision is changed but no further payment is due, a detailed letter will be sent explaining why no payment is forthcoming. A new beneficiary notice indicating the revised decision will be issued.
- If a portion of the claim can be allowed, a check will be issued for the allowed service(s), with a corrected beneficiary notice. A separate, detailed letter will be sent, explaining the adjustment and why additional payment cannot be allowed on the other service(s).

Review letters also explain the procedure for a Medicare Part B hearing, which is the 2nd level of the appeals process.

Please see the section below entitled "Liability and Appeal Decisions" for information on when any previously collected monies must be refunded to the patient.

Hearing Officer (HO) Hearing – 2nd Level of Appeal

A Medicare-appointed HO, whose role is to determine whether the carrier has followed Medicare guidelines in making its decision, conducts the hearings.

If, after a review, the appellant is still dissatisfied, and the amount in controversy (the difference between the billed amount and the Medicare allowed amount, less any outstanding deductible) is \$100 or more, a hearing may be requested. The claim(s) can be added (sometimes called aggregation) to previous or subsequent claims with which the appellant is dissatisfied to meet the requirement, as long as, the appeal is filed timely for all claims at issue and the claims are properly at the level of appeal requested.

Hearing Request Deadline

A hearing request must be filed within six months from the date of the review determination. The carrier may, upon request by the party affected, extend the period for filing the request for hearing.

Filing a Request for Hearing

A request for a hearing should be submitted in writing, clearly explaining why the review determination was unsatisfactory. It should indicate the type of hearing being requested. The request, a copy of

the review notice, and any additional useful documentation should be sent to the local Medicare carrier's HO address.

On-the-Record (OTR) Hearing

Regardless of the type of hearing requested, the HO prepares and sends to the beneficiary, physician or supplier, or his or her representative a decision based on the facts in the record, including any additional information obtained by, or furnished to, the HO. This includes all evidence submitted with the written request for a hearing unless, one of the following apply:

- The on-the-record hearing would significantly delay the hearing;
- The issue is medical necessity;
- Oral testimony and cross-examination are necessary to clarify the facts; or
- The Medicare carrier cannot provide a different HO for the requested hearing.

If an on-the-record hearing is not performed, the appellant will be notified of the date and time of the telephone or in-person hearing.

Telephone Hearing

A telephone hearing offers a convenient and less costly alternative to the "in-person" hearing, since there is no need to appear. Oral testimony and oral challenges may be conducted via telephone. The appellant and/or his or her representative may also submit additional evidence by facsimile.

In-person Hearing

Appellants and/or representatives may present oral testimony (as with telephone hearings) and written evidence supporting the claim and refuting or challenging the information the carrier used to deny it.

HO Decision Notification

Regardless of the type of hearing requested, the hearing officer will notify the claimant, in writing, of the determination. The written response will include the date and time of the in-person or telephone hearing and the option to notify Medicare if the appellant wishes to cancel the hearing based on the results of the on-the-record decision.

Administrative Law Judge – 3rd Level of Appeal

If at least \$100 remains in controversy following the HO's decision, further consideration may be made by an Administrative Law Judge (ALJ). The hearing decision will include instructions for obtaining an ALJ hearing. The request must be made within 60 days of receipt of the hearing determination. The ALJ will define hearing preparation procedures.

Departmental Appeal Board Review – 4th Level of Appeal

If a beneficiary, provider, or supplier is dissatisfied with the ALJ's decision, he or she may request a review by the Departmental Appeals Board (DAB). The DAB is the appeal level that reviews cases that have been previously adjudicated by the ALJs. There is no minimum amount remaining in controversy at the DAB level. The DAB review must be requested within 60 days of receipt of the ALJ's decision. The written request should specify the issues and findings of fact and conclusion of law made by the ALJ with which the physician disagrees.

Judicial Review in Federal Court – 5th Level of Appeal

If at least \$1,000 remains in controversy following the DAB's decision, judicial review before a federal district court judge can be considered.

Liability

The financial liability protections provisions of the Social Security Act, Sections 1834(a)(18), 1834(j)(4), 1842(1), and 1879(h), Refund Requirements (RR), and Section 1879(a)-(g), Limitation on Liability (LOL), may protect the patient and/or the physician from financial liability when Medicare denies or reduces payment for a service or item based on it being considered as “not reasonable and necessary” (or for medical equipment or supplies denied for one of three other specific reasons). Under these financial liability protections provisions, the patient may not be required to pay the physician for a service, unless certain conditions are met.

Reasonable and Necessary Services

Section 1862(a)(1) of the Medicare law prohibits payment for services and items not medically reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member or which are otherwise excluded under that section. A service or item may be considered not reasonable and necessary for reasons including, but not limited to:

- The service/item is not covered based on the diagnosis/condition of the patient.
- The frequency/duration of the service was provided beyond the accepted standards of medical practice.
- The medical documentation did not justify the medical necessity of the service/item.

The physician is generally expected to know that a service/item may be denied or reduced payment as not medically reasonable and necessary in the following situations:

- The contractor published the specific medical necessity requirements.
- The physician has received a previous review, hearing decision, or other notice for the service/item that informed him or her of medical necessity requirements.
- The physician could reasonably be expected to know the requirement based on standard medical practice within the community.
- The physician has received a denial or reduction of payment on the same or similar service/item.

Note: The remittance notice showing the denial/reduction of payment serves as formal notice of the medical necessity requirements.

Providing an Acceptable Advance Beneficiary Notice (ABN)

The ABN protects both the physician and patient from unexpected financial liability. When the physician believes that the service/item may not be covered as medically reasonable and necessary, an acceptable notice of Medicare’s possible denial of payment must be given to the patient. If the physician does not give an ABN to the patient, the physician usually cannot hold the patient financially liable for the service/item. Patients must be notified before the service is rendered that payment might be denied or reduced. The patient may then decide if he or she wants the service and is willing to pay for it.

If the physician properly notifies the patient in advance that payment for the service may be denied or reduced, the physician is not held financially liable for the services and may seek payment from the patient.

Specific Criteria for the ABN

An acceptable ABN of the denial or reduction of payment must meet the following criteria:

- The notice must be given in writing on the approved Form CMS-R-131, in advance of providing the service/item.
- The notice must include the patient's name, date and description of service/item, and reason(s) the service/item may be denied or a reduction in payment could occur.
- The patient must sign and date the ABN, indicating that the patient assumes financial liability for the service/item if payment is denied or reduced for the reasons indicated on the ABN.

ABN for Services Rendered on Referral or Order of Another Physician

Despite the limited contact with patients that some physicians have, for services provided on referral or order of another physician, they must be aware of the medical necessity requirements for the services they provide (if they have been made available). In most cases, the availability of the medical necessity requirements indicates that the physician knew, or should have known, when payment for the item/service might be denied or reduced as not medically necessary.

If, after considering the medical necessity requirements for a service/item, the physician believes a likelihood exists that payment may be denied or reduced as not medically necessary, an acceptable ABN of the denial/reduction of payment should be provided to the patient.

For services ordered by another physician (e.g., diagnostic tests), the physician who ordered the services may provide the ABN. However, the physician rendering the services will be held financially liable for the services if payment is denied/reduced and, therefore, is responsible for ensuring that an ABN is provided. Also, the rendering physician may be required to produce a copy of the ABN even if originally given by the ordering physician. Additionally, if the ABN is found to be defective, it is the rendering physician who will be financially liable for the services.

For services rendered on the referral of another physician, the physician rendering the service is in the best position to determine the likelihood of a denial/reduction in payment and, therefore, should provide an acceptable ABN to the patient.

ABN Modifiers

Assigned or nonassigned claims billed to Medicare Part B must contain modifier *GA* next to each applicable service for which a proper ABN has been given to and signed by the patient. While the ABN form need not be submitted with the claim, a copy of the signed document must be maintained with the physician's records.

Modifier *GZ* may be used to indicate a physician expects Medicare will deny an item or service as not reasonable and necessary and the beneficiary has not signed an ABN.

Liability and Appeal Decisions

Original Claim Decision Upheld On Review

For assigned and nonassigned claims, if the original claim determination is upheld on a review and the physician knew, or could have been expected to know, that payment for the service might be denied or reduced, the physician is held liable and must refund any monies previously collected from the patient for the service within 30 days from the date of the review decision.

Original Claim Decision Revised On Review

Assigned Claims

If the original claim determination is upheld on a review and it is found that the physician and beneficiary could not have been expected to know that payment for the service might be denied or reduced, Medicare Program payment is made to the physician.

Nonassigned Claims

If the original claim determination is upheld on a review and it is found that the physician could not have been expected to know that payment for the service might be denied or reduced, the physician is notified that he or she may collect payment from the patient. A letter is sent to the patient indicating that he or she is responsible for payment.

Refund of Monies to the Patient

Where the patient is not responsible for the payment of a service, the physician must refund any monies previously collected from the patient. If the physician does not refund the monies within the specified time limits, the following actions may occur:

- *Assigned claims* – The patient may submit a request to Medicare for indemnification from payment. A letter is sent to the physician stating that a refund must be made within 15 days. The refund must be for the amount actually paid to the physician, including any amounts applied to the deductible or coinsurance. If a refund is not made within 15 days, Medicare will pay the patient and request a refund from the physician for the amount paid.
- *Nonassigned claims* – The patient may notify Medicare that the physician did not refund the amount due. Medicare contacts the physician to explain that a refund is due to the patient. If a refund is not made within 15 days, the physician may be subject to civil monetary penalties and sanctions.

Overpayments

An overpayment occurs when Medicare pays more than the correct amount, often due to the following:

- Duplicate submission of the same service
- Payment to the incorrect payee
- Payment for excluded or medically unnecessary services
- Payment made as primary insurer when Medicare should have paid as secondary insurer

All Medicare payments, correct and incorrect, are transmitted to the Internal Revenue Service (IRS). If the payee is incorrect, Medicare must request return of the monies and reprocess the services correctly. Physicians must also take specific steps when overpaid by Medicare.

Physician Responsibilities in an Overpayment Situation

If Medicare pays more than the correct amount in error, the overpayment should be refunded as soon as possible, without waiting for notification. The local carrier can provide information regarding where to mail the refund. The following must be included with the refund:

- The provider number (and that of the provider who should be paid, if applicable)
- The Medicare number of the patient(s) in question, date of service, and amount overpaid
- A brief description of the reason for the refund
- A copy of the remittance notice, highlighting the claim(s) at issue
- A check for the overpaid amount

If Medicare Discovers an Overpayment Before Refund is Made

Medicare will send a letter listing the service(s) at issue, why the overpayment occurred, and the amount being requested. The physician will have 30 days from the date of the letter to mail a refund

to the address in the letter. If the refund is not received within 30 days from the date of the first letter, a second letter will be sent and the balance due will be satisfied by withholding future claim payments until the overpayment is paid in full (otherwise known as “offset”). When Medicare notifies the physician of an overpayment, and multiple claims are involved, the letter will describe all overpaid claims.

Physician Disagreement with the Overpayment

The physician has the right to appeal the decision if he or she disagrees with the overpayment. However, submitting an appeal does not prevent an offset. An explanation of why he or she believes the overpayment to be incorrect should be included with the appeal.

Medicare Collects Interest on Unpaid Overpayments

Medicare is required to collect interest on overpayments not satisfied within 30 days from the date of the initial refund request letter.

Questions

The physician should contact the local Medicare contractor with questions about the overpayment process or steps to take when there is a potential overpayment.

Chapter 9 – BUSINESS RELATIONS AND PAYMENT ACCURACY

Congress assigned the Centers for Medicare & Medicaid Services (CMS) the fiduciary duty to ensure beneficiaries receive the maximum value for their invested dollars in the taxpayer-funded Medicare Program. Establishing and maintaining solid business relations between physicians and the Medicare Program is critical to delivery of effective healthcare and essential to protect these invested dollars or what is more commonly referred to as the Medicare trust fund. As in any business relationship, understanding each other's expectations and capabilities is important. To accomplish this, physicians, CMS, Congress, and local Medicare contractors must work together.

Physicians should create and maintain sound business relations by reviewing and becoming familiar with requirements published by the Medicare contractor, CMS, or the Social Security Administration prior to entering into contractual arrangements with others (e.g., hospitals, other physicians, laboratories, billing services, consultants, and billing staff). Additionally, physicians who enter into contractual arrangements must self-monitor within their organization to ensure the propriety of interactions with Medicare, as well as with other entities with which the physician conducts business.

CMS has improved business relations by significantly increasing its staff of physicians who actively consult with their peers to address healthcare issues. Another CMS initiative is the Physician's Regulatory Issues Team (PRIT). The PRIT continually reviews and encourages streamlining, simplifying, and clarifying policies and procedures that affect practicing physicians. The Medicare Program's overall goal is to be supportive of physicians as they provide care to people with Medicare.

Since the smallest error percentage may result in billions of dollars in losses to the Medicare trust fund, Congress established the Medicare Integrity Program (MIP) in 1996 to ensure that Medicare pays claims correctly. This means paying the correct amount, for a covered service, provided to an eligible beneficiary by an enrolled physician. The emphasis is on making accurate payments when claims are first submitted because increased accuracy and efficiency benefit everyone involved in the system.

In 1996, the Office of Inspector General (OIG) office estimated that 14 percent of all Medicare payments were made improperly. Since then, the payment error rate has been significantly reduced to 6.3 percent in 2002. The credit for such improvement in payment accuracy goes to physicians, providers, beneficiaries, Department of Health and Human Services, Department of Justice, OIG, state agencies, Congress, and the President's administration. CMS' goal for 2003 is to reduce the payment error rate to 5 percent or less.

Helping Medicare “Pay It Right”

Education

Most errors are addressed administratively when they are first encountered, by collecting overpayments identified in specific cases or claims and by engaging in education. Physicians, providers, and other suppliers should understand Medicare Program requirements pertaining to their business, so they can correctly bill for services and items.

The Medicare Learning Network at www.cms.gov/medlearn on the Internet, assists with proper submission of Medicare claims through a variety of free educational materials and resources including:

- Information about the basics of coding and claims payment
- Quick reference guides

- Web-based training modules
- Resident training information, including a manual of Medicare basics useful to physicians at all stages of practice
- Educational product ordering

Additional contractor resources available to assist physicians with problem solving or to assist with determining the proper way to code and bill for specific services include:

- Local Medicare Carrier Web sites which contain announcements about educational events, answers to frequently asked questions, and on-line versions of bulletins or newsletters
- Local Medicare Carrier toll-free phone numbers where customer service representatives can provide clear answers to billing questions. A listing of the toll-free numbers is available at www.cms.gov/medlearn/tollnums.asp on the Internet.

Local Medical Review Policy

Local Medical Review Policy (LMRP) is an educational and administrative tool to assist physicians, providers, and suppliers in submitting correct claims for payment. Contractor medical directors and staff develop LMRPs with input from the public. LMRPs outline how contractors will review claims to determine if Medicare coverage requirements have been met. CMS requires local policies be consistent with national guidance (they may be more detailed or specific), developed with input from medical professionals (through advisory committees), and created cognizant of scientific evidence and clinical practice.

The use of LMRPs helps avoid situations in which claims are paid or denied without a full understanding of the basis for payment and denial. Medicare contractors make many case-by-case decisions. LMRPs encourage consistency and allow contractors to clarify and publish their decisions. Physicians can also request national coverage determinations, if there is sufficient medical evidence to support the appropriate conditions and indications for payment of a given service, procedure, or technology.

LMRPs:

- May be obtained from the local Medicare Carrier Web site, the toll-free customer service phone number, or on the LMRP national database at www.lmrp.net on the Internet.

National Coverage Determinations:

- Are located in the Medicare Coverage Issues Manual available at www.cms.hhs.gov/manuals on the Internet. They are also available through the CMS Web site at www.cms.hhs.gov/ncd on the Internet.

Ensuring Payment Accuracy

Documentation

Medicare strives to minimize its documentation requirements for most services and place no additional paperwork burden on physicians. Sometimes, as with Certificates of Medical Necessity, extra documentation is required. Many situations may cause Medicare to request documentation for services or items furnished. Physicians should document the service or item at or as close as possible to the time it was furnished, since late entries increase the likelihood of inaccuracies, and may raise questions regarding the cause of the delay.

Honest mistakes may happen when submitting claims to Medicare. Physicians who make unintentional coding errors do not commit fraud, and CMS does not impose fines for unintentional coding errors. However, when overpayments are identified, CMS is required by law to recover them.

Procedure Code Selection

Providers should choose billing and revenue codes carefully, based on medical necessity as supported in the documentation. If this responsibility is delegated, providers must ensure their staff understands coding principles, as providers are responsible for all claims submitted on their behalf. Contractual arrangements do not relieve physicians of this responsibility. Additionally, providers should conduct quality checks to ensure agreement with selected codes, and review coding manuals carefully to ensure proper code selection.

Duplicate Claims

Approximately six percent of all claims filed to Medicare are denied as duplicate claims. Wherever possible, Medicare works with physicians to eliminate duplicate claims.

Duplicate claims submission can occur from time to time; however, Medicare expects this rate to be less than one percent of all claims processed for a particular physician. Physicians submitting large volumes of duplicate claims are identified to work with the Medicare contractor, to learn about alternatives to duplicate filing.

Medicare may remove physicians who repeatedly submit duplicate claims from the electronic billing network. This is determined on a case-by-case basis.

Overpayments

Overpayments are Medicare funds a physician, supplier or beneficiary has received in excess of amounts due and payable under Medicare statute and regulations. Once it has been determined an overpayment has been made, the amount of the overpayment is a debt owed to the United States Government. Statutory law strictly requires CMS to seek recovery of overpayments regardless of how an overpayment is identified or caused, including when an overpayment is a mistake made by CMS.

Medicare strives to ensure payment accuracy however, mistakes occasionally occur. Physicians are responsible for making voluntary refunds to Medicare when they identify an overpayment. Additionally, physicians are responsible for timely repayment when Medicare notifies them of an overpayment. If a timely repayment is not made after proper notice, interest will accrue at an annual rate specified by law on the outstanding balance. Finally, penalties may be imposed on overpaid monies, depending on the circumstances involved in the case.

Part A and Part B manage overpayments in different ways:

- Part A overpayments for provider services not performed or incorrectly paid for any other reason are resolved through credit balance reports.
- Part B overpayments must be returned to the local Medicare carrier; physicians must not keep incorrect payments. These overpayments may often require refund of copayments made by or on behalf of beneficiaries.

Physicians who may have questions related to a Medicare overpayment and/or other Medicare debt collection should contact the local Medicare carrier for assistance.

Lost or Stolen Medicare Cards

Every year, Medicare receives thousands of calls and letters from beneficiaries stating their Medicare cards have been lost or stolen and used by others. Identity fraud, in the form of beneficiary impersonation, is a serious problem.

Physicians should consider photocopying each beneficiary's driver license or some other form of valid picture identification. With this type of identification on file, office staff can quickly look at the picture on record to ensure that the patient receiving the service is actually the beneficiary named on the Medicare card.

The physician is responsible for verifying the identity of all patients receiving services. Physicians should be cautious of receiving false addresses, telephone numbers, or Medicare cards from their patients. If services are rendered to a beneficiary impersonator, the physician may be liable for an overpayment.

In the case of suspected identity fraud, physicians are encouraged to contact their Medicare contractor or call the national Department of Health and Human Services/Office of Inspector General (DHHS/OIG) hotline directly at: 1-800-HHS-TIPS.

Offers of Free or Discounted Services

If a physician advertises services or a portion of services for free, he or she must not bill the services to Medicare or any supplemental policy.

Medicare requires that beneficiaries pay coinsurance on most services. Providing such services at no charge to the beneficiary and billing Medicare (or both Medicare and the patient's supplemental insurer) constitutes a routine waiver of coinsurance and is unlawful, subjecting a physician to Civil Monetary Penalties (CMPs) or other penalties. However, the waiver of coinsurance or deductibles would not be considered unlawful, if the beneficiary was unable to pay (e.g., indigence or poverty), and this information is documented in the patient's medical record.

Protecting Your Practice

Obtaining a Medicare Billing Number

To bill Medicare, physicians and other suppliers must first obtain a Medicare billing number referred to as a Provider Identification Number (PIN). To obtain a PIN physicians and other suppliers must complete the appropriate CMS 855 form (provider/supplier enrollment application) and submit it to the Medicare contractor. The PIN is used to bill Medicare for services or items furnished. Physician/suppliers should protect their PIN like a credit card number and ensure that others do not use it to bill Medicare without their knowledge. Any misuse of the PIN should be reported immediately. Please refer to Chapter 2, Medicare Part B Physician Enrollment, for more information.

Closing, Relocating, Change In Status, or Changes In Members

Physicians and other suppliers are required to contact Medicare to update records. Additional information regarding application for billing numbers, adding/deleting group members, or changes to addresses is available through the CMS Web site at www.cms.gov/providers/enrollment on the Internet.

Medicare Part A Providers

Providers wishing to obtain application information or to make changes to an existing application or file must contact the fiscal intermediary responsible for their enrollment.

Medicare Part B Physicians/Suppliers

Physicians or other suppliers must inform their Medicare contractor if they decide to close or move their practice or change members of a group. PINs must be updated in Medicare's database so that another physician or entity cannot use it. Please refer to Chapter 2, Medicare Part B Physician Enrollment, for more information.

Reassignment of Benefits

Generally speaking, Medicare pays the physician who performed the service. In limited situations, however, Medicare may allow the performing physician to reassign Medicare payments to another physician or entity. This is called reassignment of benefits and requires that various forms be completed, signed, and returned to the Medicare contractor.

A fully executed Reassignment of Benefits form (CMS 855R) is powerful because it allows another person or entity to bill Medicare on the physician's behalf and receive payment that otherwise would have been sent directly to the physician. If a physician has authorized someone else to bill and be paid by Medicare for services that he or she renders, the physician retains responsibility for ensuring that such billings are appropriate and reflect services actually performed.

Revoking Reassignment Agreements

Physicians should notify Medicare as soon as reassignment agreements become outdated or are no longer valid, since failure to do so allows the previous entity to continue billing Medicare. Physicians and suppliers may formally revoke reassignment agreements by completing and submitting the appropriate CMS 855 form to the Medicare contractor.

Hiring Someone to Prepare Claims

Some physicians and suppliers find it helpful to obtain the assistance of a billing service or consultant to submit their Medicare claims. While such entities can provide valuable services, physicians/suppliers must clearly understand that delegating this process does not relieve them from responsibility for overpayments received due to claims filed on their behalf. Therefore, physicians/suppliers should get involved and oversee their billing service or staff. Additionally, before hiring a service or consultant, physicians/suppliers should carefully check references and ensure that the service or consultant:

- Provides periodic reports of claims billed on the physician's behalf and, if the billing service receives the Medicare payments, it should be able to provide data regarding how much Medicare paid
- Protects the physician's PIN and any other information used to act on the physician's behalf
- Does not change procedure codes, diagnosis codes, or other information furnished by the physician without the physician's knowledge and consent
- Keeps the physician informed of all correspondence received from Medicare

Physicians should review information submitted by a billing service or consultant regularly to ensure consistency with their records. They should also keep complete administrative records for the claims a billing service files on the their behalf.

Hiring Employees

The physician is responsible for the actions of his or her billing staff. Therefore, physicians should perform background checks before hiring new employees and conduct periodic quality checks of sensitive processes, such as the posting of account receivables.

Contractual Arrangements

Numerous legal and compliance factors must be considered when contracting with individuals, other entities, billing services, or consultants. The following questions should be considered when planning contractual arrangements:

- What types of agreements and paperwork must be executed between the physician and the other parties?
- Are any agreements/paperwork required between the physician and the insurance companies?
- Do the agreements made between the physician and the other parties conform to ethical standards of conduct as well as state and federal regulations?

Contracts must be examined in light of confidentiality obligations, including those defined in the Health Insurance Portability and Accountability Act of 1996. Therefore, physicians should consult with a healthcare attorney when considering a contractual arrangement. Additionally, physicians may obtain information on contractual arrangements by reviewing requirements published by the Medicare contractor, CMS, or the Social Security Administration.

Referral of Patients and Ordering of Services/Items

Physicians sometimes need to refer patients for specialized medical care or to receive certain diagnostic tests or supplies. In such cases, physicians should consider the following:

- Implement a process to ensure that only the ordered services or tests were rendered. For example, when reviewing the results of diagnostic tests, note whether the other provider performed additional or more complex tests than those ordered. The ordering physician's PIN must be protected against misuse.
- Whenever possible, specify the reason for ordering the services. If diagnostic tests are ordered as part of a routine physical exam, include that fact with the referral. Physicians should not empower the other provider who files the Medicare claim to determine why the tests were needed.
- *Never sign blank certification forms* that are used by other providers to justify Medicare payment for oxygen, home health services, wheelchairs, hospital beds, prosthetic devices, etc. Be sure to personally complete all medical information on such forms. Demographic information, such as patient name and address should be fully completed by the supplier or physician.
- Medical services, supplies, and devices are sometimes aggressively marketed to beneficiaries, with little regard for the medical condition, examples include: transcutaneous electrical nerve stimulator devices and power operated scooters. While these devices are helpful for some beneficiaries, physicians should use extreme caution when prescribing or ordering them, due to the creative ways they are sometimes marketed. Medicare can pay for items or services that are medically necessary. Certification forms include helpful information about eligibility for the service or product being prescribed.
- Where applicable, specify the quantity of medical supplies or the duration of services needed for a patient. *An open-ended certification is like giving someone a blank check.* Recent cases show Medicare being billed by suppliers providing items that were, in fact, certified by a physician but delivered in staggering quantities.
- Be suspicious of offers, discounts, free services, or cash to order services. *If a deal sounds too good to be true, it probably is.* Physicians should contact the OIG or a healthcare attorney if they

believe a business arrangement places them at risk. The penalties for violating Medicare's Anti-Kickback Statutes can be severe.

- *Never* certify the need for medical services or supplies for patients who have not been seen and examined.

Compliance Programs

To ensure Medicare claims are submitted and paid accurately, the OIG issues guidance on compliance programs. A compliance program is a tool that allows physicians to be confident their practices are lawful and compliant with Medicare requirements. The OIG works closely with CMS, the Department of Justice, and affected sectors of the healthcare industry to formulate this guidance. The OIG has identified seven fundamental elements to an effective compliance program:

- Implement written policies, procedures, and standards of conduct
- Designate a compliance officer and compliance committee (e.g., a billing clerk and physician in a small practice)
- Conduct effective training and education
- Develop effective lines of communication
- Enforce standards through well-publicized disciplinary guidelines
- Conduct internal monitoring and auditing
- Respond promptly to detected offenses and develop corrective action plans

Although compliance programs are voluntary, adopting one could be beneficial to a healthcare provider or any entity involved in the healthcare industry. Implementing a compliance program may assist in establishing a culture that promotes prevention, detection, and resolution of situations that do not conform to program requirements.

Those interested in implementing a compliance program based on the OIG's published guidance must understand the guidance in itself is NOT a compliance program. Rather, it is a set of guidelines to consider in implementing such a program. Detailed policies and procedures of a compliance program are left to the discretion of each provider/entity. In this way, implementation of a compliance program is flexible to account for the nature of the business, its size and resources.

A compliance program should be tailored to the organization. It should effectively articulate and demonstrate the commitment of the physician or entity to legal and ethical conduct. Eventually, a compliance program should become part of the routine operation of an organization.

A compliance program does not grant the healthcare provider or other organization immunity from scrutiny and/or corrective action by the government or any federal, state, or private payer healthcare program. However, the OIG has committed itself to take such plans into consideration in any investigation.

Criminal Liability

Criminal liability for false claims submission can occur for knowingly and willfully making a false statement when billing for services. The healthcare entity and individual physicians can be criminally liable for the actions of employees when their conduct is carried out within the scope of employment, even if their conduct is a violation of the organization's policy. For example, a hospital discovered, months after the acquisition of a physician practice, ongoing miscoding of an excluded service into a covered service. Under the federal definition, this may be considered fraud, and the hospital may be

liable for the physician's and billing clerk's activities. Sometimes, the law holds people responsible for what they "should have known."

When a healthcare provider is convicted of criminal activity, federal sentencing guidelines determine the extent of the penalty. These guidelines are mandatory and must be applied by the court upon conviction of the provider. The guidelines provide a complicated and elaborate point system to arrive at the appropriate range of punishment, adding points for "bad" factors and subtracting points for "good" factors.

One factor that may reduce the point calculation is the existence of an effective compliance program. Although the likelihood of criminal prosecution is low, a compliance program may not only be effective in mitigating the sentence, should such prosecution occur, but may also detect potential criminal violations before they occur.

Implementing a Compliance Program

There are several steps in implementing and operating an effective compliance program. Of course, the compliance program must be customized to meet the needs of the organization and must be capable of practical implementation with as little interruption to daily operations as possible. The following steps may be considered when implementing a compliance program:

- Making initial organizational decisions
- Obtaining board approval to implement a program
- Forming a compliance team
- Developing compliance standards
- Implementing the program
- Monitoring and auditing
- Enforcing and correcting
- Responding and preventing
- Updating the program

The documents issued by the OIG on compliance program guidance are published in the Federal Register and are available through the OIG Web site at:

<http://oig.hhs.gov/fraud/complianceguidance.html> on the Internet.

The purpose of all compliance programs is to:

- Recognize real and unavoidable responsibilities of practicing physicians
- Increase self-awareness of inappropriate business relations or practices

Compliance programs are designed to protect the integrity of the healthcare system, and physicians are encouraged to partner with local Medicare carriers in this endeavor.

Chapter 10 – PROTECTING THE MEDICARE TRUST FUND

Physicians, providers, and other suppliers have an obligation, under law, to conform to the requirements of the Medicare Program. While most individuals or organizations are honest and make every effort to adhere to the guidelines set forth in the Medicare Program, there are a few that are dishonest. Further, the high monetary amount billed to the Medicare Program makes it vulnerable to individuals who may inappropriately administer medical and healthcare services or bill for services never rendered. The Centers for Medicare & Medicaid Services (CMS) must take strong action to combat fraud and protect the Medicare trust fund. The goal is to make sure Medicare only does business with legitimate physicians and suppliers who provide Medicare beneficiaries with needed high quality services.

The effort to prevent and detect fraud is a cooperative one that involves:

- CMS
- Medicare beneficiaries
- Medicare contractors
- Physicians
- Quality Improvement Organizations (QIO)
- State and Federal Law Enforcement Agencies such as, the Office of Inspector General (OIG) of the Department of Health and Human Services (HHS), the Federal Bureau of Investigation (FBI), and the Department of Justice (DOJ)

The primary role of each of these individuals/agencies is to:

- Identify cases of suspected fraud
- Investigate suspected fraud cases thoroughly and in a timely manner
- Take immediate action to ensure that Medicare trust fund dollars are not inappropriately paid out and that any payments made in error are recouped

Suspension and denial of payments and the recoupment of overpayments are some of the actions that may be taken. When appropriate, cases are referred to the OIG, Office of Investigations Field Office, for consideration and initiation of criminal actions, civil monetary penalties, or administrative sanction.

The most frequent kind of fraud arises from a false statement or misrepresentation made, or caused to be made, that is material to entitlement or payment under the Medicare Program. The violator may be a provider, a beneficiary, a physician or other practitioner, supplier of Durable Medical Equipment (DME), an employee of a physician or practitioner, or some other person or business entity including a billing service or a contractor employee.

Fraud committed against the program may be prosecuted under various provisions of the United States Code and could result in the imposition of restitution, fines, and, in some instances, imprisonment. In addition, there is also a range of administrative sanctions (i.e., exclusion from participation in the program) and civil monetary penalties that may be imposed when facts and circumstances warrant such action.

Individuals or organizations identified as engaging in potentially inappropriate activities are not subject to automatic prosecution. Stewards of the Medicare Program (i.e., the federal government, its

agencies, and its contractors) must be prudent and treat physicians or other providers fairly when making decisions that will affect them or their organizations.

Investigation and prosecution of healthcare fraud are reserved for willful and intentional acts of wrongdoing, substantiated through documented inappropriate billing patterns. To address other inappropriate activities or payments, safeguard measures, rather than punitive measures, may be taken.

To ask questions about fraud and abuse or to report suspected fraudulent or abusive activities, providers are encouraged to contact their Medicare contractor or call the national Department of Health and Human Services/Office of Inspector General (DHHS/OIG) hotline directly at: 1-800-HHS-TIPS.

Medicare Fraud and Abuse Defined

What Is Fraud?

Fraud is the intentional deception or misrepresentation that an individual knows to be false or does not believe to be true and makes, knowing that the deception could result in some unauthorized benefit to himself/herself or some other person.

Examples of Fraud

The following are examples of fraud:

- Billing for services that were not furnished and/or supplies that were not provided
- Billing for services as if performed by a particular entity when they were, in fact, performed by another entity not eligible to be paid by Medicare
- Using an incorrect or inappropriate provider number in order to be paid (e.g., using a deceased provider's number to defraud Medicare)
- Signing blank records or certification forms or falsifying information on records or certification forms to obtain Medicare payment
- Selling or sharing patients' Medicare numbers so false claims can be filed
- Offering incentives to Medicare patients that are not offered to non-Medicare patients (e.g., routinely waiving or discounting the Medicare deductible and/or coinsurance amounts)
- Offering, soliciting, or accepting bribes, kickbacks, or discounts for the referral of patients or order of services or items
- Falsely representing the nature of the services furnished which encompasses describing an excluded service in a misleading way that makes it appear as if a covered service was actually furnished (e.g., billing routine foot care as a more involved form of foot care or billing for physical therapy when acupuncture was actually performed)
- Falsifying information on applications, medical records, billing statements, and/or cost reports or any statement filed with the government
- Misrepresenting excluded services as medically necessary by using inappropriate procedure or diagnosis codes

What Is Abuse?

Abuse describes practices that either directly or indirectly, results in unnecessary costs to the Medicare Program. Many times abuse appears quite similar to fraud except that it is not possible to establish that abusive acts were committed knowingly, willfully, and intentionally. Although these types of practices may initially be categorized as abusive in nature, under certain circumstances they may

develop into fraud if there is evidence the subject was knowingly and willfully conducting an abusive practice.

Examples of Abuse

The following are examples of abuse:

- Charging in excess for services or supplies
- Providing medically unnecessary services
- Providing services that do not meet professionally recognized standards
- Billing Medicare based on a higher fee schedule than for patients not on Medicare
- Submitting bills to Medicare that are the responsibility of other insurers under Medicare Secondary Payer regulations
- Violating the participating physician/supplier agreement with Medicare or Medicaid
- Breaches in the assignment agreement
- Violating the Maximum Allowable Actual Charge limits or limitation amount

Fraud and Abuse Case Examples

The following are some actions the government took in actual cases involving Medicare providers:

- An unlicensed physician utilized provider numbers of other physicians, without their knowledge, to bill Medicare for services not rendered. The doctor pled guilty in Federal court to money laundering and filing false claims. He was sentenced to 18 months in prison and required to reimburse the government in excess of \$750,000.
- An unlicensed doctor cheated the government for three years by billing Medicare for visits to homebound patients using other physicians' Medicare provider numbers. He pled guilty to money laundering and, as a result, had to forfeit his home, many acres of undeveloped property, a late-model luxury car, and a year-old cabin cruiser. This property was worth an estimated \$750,000 (about half the amount he was accused of receiving from Medicare). He also faces up to ten years in prison.
- Institutional providers separately billed Medicare for nonphysician outpatient services provided in conjunction with inpatient admissions. These providers were collectively cited for possible estimated damages in excess of \$30 million, including recovery of duplicate payments, liability for penalties, and triple damages of not less than \$5,000 per claim.
- An independent clinical laboratory chain billed Medicare for laboratory tests that were not ordered by a physician and were not medically necessary. The laboratory entered into a civil settlement with the government and agreed to reimburse over \$46 million to the Medicare Program.

Identification and Prevention of Fraud

Whistle Blower Cases

The "Whistle Blower," or the "qui tam" provision, as it is formally called, allows any person having knowledge of a false claim against the government to bring an action against the suspected wrongdoer on behalf of the United States Government. A person who files a qui tam suit on behalf of the government is known as a "relator" and may share a percentage of the recovery realized from a successful action. A "relator" can be a patient, disgruntled former employee, or other business contact.

Incentive Reward Program

Section 203(b)(1) of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 (Public Law 104-191), established a program to encourage individuals to report information on individuals and entities that are engaged in or have engaged in acts or omissions that constitute grounds for the imposition of a sanction under sections 1128, 1128A, or 1128B of the Social Security Act (the Act), or who have otherwise engaged in sanctionable fraud and abuse against the Medicare Program under title XVIII of the Act.

The Medicare Incentive Reward Program (IRP) was established to pay an incentive reward to individuals who provide information on Medicare fraud and abuse or other sanctionable activities.

The Medicare Program will make a monetary reward only for information that leads to a minimum recovery of \$100 of Medicare funds from individuals and entities determined by CMS to have committed sanctionable offenses. Only referrals from intermediaries and carriers to the OIG, made pursuant to the criteria set forth in the Program Integrity Manual (PIM), Chapter 3, section 10ff are considered sanctionable for the purpose of the Incentive Reward Program.

The amount of the reward will not exceed 10 percent of the overpayment recovered in the case, or \$1,000, whichever is less. Collected fines and penalties are not included as part of the recovered money for purposes of calculating the reward amount.

Additional information regarding the IRP may be obtained from Chapter 2 of the Medicare Program Integrity Manual, available at www.cms.hhs.gov/manuals/108_pim/pim83toc.asp on the Internet.

Pre- and Postpayment Review

Medicare contractors have a responsibility to ensure that claim payments are made appropriately. One way to do this is to review claims and medical records on either a prepayment or postpayment basis. Medicare may ask the physician to submit documentation for a detailed review of his or her claims. After the review, payment may be allowed, denied, reduced, or recovered.

If fraud is suspected or continued noncompliance with Medicare requirements is demonstrated, despite documented educational interventions, a referral may be made to the Benefit Integrity Department of the Medicare contractor for investigation and possible payment suspension.

Overpayments

Overpayments are Medicare funds a physician, provider, supplier, or beneficiary has received in excess of amounts due and payable under the Medicare statute and regulations. Once it has been determined an overpayment has been made, the amount of the overpayment is a debt owed to the United States Government. Statutory law strictly requires CMS to seek recovery of overpayments regardless of how an overpayment is identified or caused, including when an overpayment is a mistake made by CMS.

Medicare strives to ensure payment accuracy however, mistakes occasionally occur. Physicians are responsible for making voluntary refunds to Medicare when they identify an overpayment. Additionally, physicians are also responsible for timely repayment when Medicare notifies them of an overpayment. If a timely repayment is not made after proper notice, interest will accrue at an annual rate specified by law on the outstanding balance. Finally, penalties may be imposed on overpaid monies, depending on the circumstances involved in the case.

Medicare Part A and Part B manage overpayments in different ways:

- Part A overpayments for provider services not performed or incorrectly paid for any other reason are resolved through credit balance reports.

- Part B overpayments must be returned to the local Medicare carrier; physicians must not keep incorrect payments. These overpayments may often require the refund of copayments made by or on behalf of beneficiaries.

Physicians who have questions related to a Medicare overpayment and/or other Medicare debt collection should contact the local Medicare carrier's toll free customer service number for assistance.

Administrative Sanctions

Denial or Revocation of Application

CMS has the authority to deny or revoke an individual or organization's application for a Medicare provider number if there is evidence of impropriety (e.g., previous convictions, false information on the application) or if the physician does not meet state/federal licensure or certification requirements. If changes have occurred to information on original applications for Medicare provider numbers, individual physicians or organizations must notify the applicable Medicare contractor or state agency. Examples of such changes may include address change, change of ownership, change in the name of the business, or change in the tax identification number. Failure to notify Medicare of changes may result in revocation of provider billing privileges, thereby preventing payments from Medicare.

Additional information regarding application for provider numbers, adding/deleting group members, or changes to addresses is available at www.cms.gov/providers/enrollment on the Internet.

Suspension of Payments

CMS has the authority to suspend payment to a physician if fraud is suspected or if a potential overpayment exists. This action may be necessary in order to protect the Medicare Program against financial loss. Payment suspensions may last up to 180 days and, in certain cases, an additional 180-day payment suspension may be imposed or the payment suspension may be imposed for an indefinite period.

Claims submitted by a physician during a payment suspension will continue to be processed, and the physician will continue to be notified of claim determinations. In addition, appeal rights are available for the processed claims. However, Medicare withholds the actual payment(s) for the claims. The withheld payment(s) may be used to recoup overpaid funds identified by Medicare.

There are no appeal rights to the decision to suspend payments. However, physicians may submit written rebuttals addressing why a payment suspension should not be imposed. A payment suspension may be lifted once the overpaid funds are recovered or if sufficient information is in the physician's rebuttal statement to demonstrate that the payment suspension is not necessary.

Civil Monetary Penalties

Section 1128A(a) of the Social Security Act authorizes the imposition of Civil Monetary Penalties (CMP) when it is determined that a person or entity has violated Medicare rules and regulations. The following are some examples of violations for which CMPs and additional assessments may be imposed (and in some instances, exclusion from the program may apply):

- Violation of the Medicare assignment provisions
- Violation of the Medicare physician or supplier agreement
- False or misleading information expected to influence a discharge decision
- Violation of assignment requirement for certain diagnostic clinical laboratory tests
- Violation of requirement of assignment for nurse-anesthetist services

- Supplier refusal to supply rental DME supplies without charge after rental payments may no longer be made
- Physician billing for assistants at cataract surgery without prior approval of PRO
- Hospital unbundling of outpatient surgery costs
- Hospital/responsible physician “dumping” of patients based upon their inability to pay or lack of resources

Typically, penalties involve assessments of significant damages such as CMPs up to \$10,000 per violation and exclusion from the Medicare Program.

Investigations

In cases of substantiated allegations of fraud or suspected inappropriate activities, Medicare contractors and/or federal law enforcement may investigate individuals or providers for subsequent prosecution.

Criminal Prosecutions and Penalties

Because it is a federal crime to defraud the United States Government or any of its programs, individuals who commit fraud may be imprisoned, fined, or both. Criminal convictions usually include restitution and significant fines. In some states, providers and healthcare organizations may also lose their licenses. Convictions may also result in exclusion from Medicare for a specific length of time. Depending on the case, the United States (U.S.) Attorney’s Office may invoke one or more federal statutes, including the examples below, to indict and prosecute individuals and/or entities involved:

- 18 U.S.C. Section 201, Bribery
- 18 U.S.C. Section 287, False claims
- 18 U.S.C. Section 371, Conspiracy to commit fraud
- 18 U.S.C. Section 669, Theft or embezzlement in connection with healthcare
- 18 U.S.C. Section 1001, False statements
- 18 U.S.C. Section 1035, False statements relating to healthcare
- 42 U.S.C. Section 1320, Kickbacks
- 18 U.S.C. Section 1341, Mail fraud
- 18 U.S.C. Section 1343, Wire fraud
- 18 U.S.C. Section 1347, Healthcare fraud
- 18 U.S.C. Section 1518, Obstruction of a federal healthcare fraud investigation
- 18 U.S.C. Sections 1956-57, Money laundering
- 18 U.S.C. Section 1962, Racketeer Influenced and Corrupt Organizations Act

Civil Prosecutions and Penalties

The U.S. attorney may file a civil suit or decide the interest of the Medicare Program is best served by settling a case. In these situations, the amount of damages plus additional money may be paid to the government in the form of penalties and fines. Depending on the severity of the case, the civil suit or settlement may include the following:

- CMP to the government for no more than \$10,000 for each item or service in noncompliance (or higher amounts where applicable by statute)
- Penalty assessment payment to the government for up to three times the amount claimed for each item or service in lieu of damages sustained by the government
- Exclusion from Medicare or any other federally funded program for a specified number of years
- Imposition of a corporate integrity agreement with the federal government. In these instances, the physician or entity is required to accomplish specific goals (e.g., educational plan, corrective action plan, reorganization) and is also subject to periodic audits by the government.

Exclusion Authority

The OIG has the authority to exclude (sanction) physicians who have been convicted of healthcare related offenses. A mandatory exclusion exists if a fraud conviction exists. In the absence of a conviction, the OIG may permissively exclude physicians if certain conditions and requirements have been met. Even when the U.S. Attorney's Office declines to prosecute a case, the OIG may act to exclude the physician from the Medicare Program. The term exclusion means that, for a designated period, Medicare, Medicaid, and other government programs will not pay the physician for services performed or for services ordered by the excluded party.

In addition, under Section 1128A(a) of the Social Security Act, many of the penalties imposed under this section may also cause exclusion from the Medicare Program. The authority to exclude physicians under this statute is delegated to CMS or the OIG depending on which agency was delegated authority for the specific violation from the Secretary.

Mandatory Exclusions

A mandatory exclusion exists if there is a conviction of fraud. Listed below are a few examples of mandatory exclusions, which can be found in the following sections of the Social Security Act:

Section 1128(a)(1) – Program-related conviction

The OIG is required to exclude individuals and entities that have been convicted of a crime related to Medicare or other State healthcare programs. The minimum mandatory period of exclusion for these types of convictions is five years.

Section 1128(a)(2) – Conviction for patient abuse or neglect

The OIG is required to exclude individuals and entities that have been convicted of a crime relating to the abuse or neglect of a patient. The minimum mandatory period of exclusion for these types of convictions is five years.

Section 1128(a)(3) – Felony conviction related to healthcare fraud

The OIG is required to exclude individuals and entities that have been convicted of an offense in connection with the delivery of a healthcare item or service or with respect to any act or omission in a healthcare program operated by or financed in whole or in part by any federal, State, or local government agency, of a criminal offense consisting of a felony relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct.

Section 1128(a)(4) – Felony conviction related to controlled substances

The OIG is required to exclude individuals and entities that have been convicted of a criminal offense consisting of a felony relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

Permissive Exclusions

A permissive exclusion exists when there is no conviction of fraud, however, certain conditions and requirements have been met. Listed below are a few examples of permissive exclusions, which can be found in the following sections of the Social Security Act:

Section 1128(b)(1) – Conviction related to fraud

The OIG may exclude individuals and entities that have been convicted of certain types of crimes that are not directly related to the delivery of items or services under Medicare or other State health-care programs. This section covers convictions for fraud, theft, embezzlement, breach of fiduciary responsibility, and other financial misconduct.

Section 1128(b)(2) – Conviction related to obstruction of an investigation

The OIG may exclude any individual or entity convicted under federal or State law of interference with, or obstruction of, any investigation into a criminal offense involving program-related convictions. Some of the types of convictions covered by this section are perjury, witness tampering, and obstruction of justice.

Section 1128(b)(3) – Misdemeanor conviction related to controlled substances

The OIG may exclude any individual or entity convicted of a criminal offense relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance. The OIG limits sanctions under this authority to those individuals or entities that have a relationship to any health-care activity.

Section 1128(b)(4) – License revocation or suspension

The OIG may impose an exclusion that will prevent a physician who has lost a license in any state from being reimbursed for treating program beneficiaries in every state, even if he has a license in another State. This section refers to licenses that have been revoked, suspended, or otherwise lost for reasons bearing on the individual's integrity. The term otherwise lost is intended to cover any situation where the effectiveness of the person's license to provide healthcare has been interrupted or precluded, regardless of the term used in a particular jurisdiction.

Payment Denials Due to Exclusion**Denial of Payment to an Excluded Party**

Medicare will not pay an excluded individual or entity that has accepted assignment. Nor will Medicare pay a beneficiary submitting claims for items and services furnished on or after the effective date of a sanction. In addition, Medicare will not pay for services/items furnished on the order or referral of an excluded individual or entity.

Denial of Payment to a Supplier

A supplier (e.g., DME supplier or laboratory) that is wholly owned by an excluded party will not be paid by Medicare for items and services furnished on or after the effective date of the sanction.

Denial of Payment to a Provider of Service

A provider of service that is wholly owned by an excluded party will not be paid by Medicare for services performed or items received (including services performed under contract) by an excluded party on or after the effective date of the sanction.

Denial of Payment to Beneficiaries

If a beneficiary submits claims for items or services furnished by an excluded party or by a supplier that is wholly owned by an excluded party on or after the effective date of the sanction:

- Medicare may pay for the first claim submitted by the beneficiary, and Medicare will immediately give the beneficiary notice of the sanction.
- Medicare will not pay the beneficiary for items or services furnished more than 15 days after the date of the notice to the beneficiary.

Exceptions to Payment Denials

Payment is available for services or items provided up to 30 days after the effective date of the sanction for:

- Inpatient hospital services or post-hospital skilled nursing facility services or items furnished to a beneficiary who was admitted to a hospital or skilled nursing facility before the effective date of the sanction
- Home health services or items furnished under a plan of treatment established before the effective date of the sanction

The Medicare and Medicaid Patient and Program Protection Act of 1987 (P. L. 100-93) permits payment for an emergency item or service furnished by an excluded individual or entity.

Reinstatement

At the conclusion of the designated period of sanction, an individual and/or entity may be eligible for reinstatement to the Medicare Program and may apply to the OIG, or where applicable CMS, for reinstatement.

OIG Sanctioned and Reinstated Provider Lists

The OIG's sanctioned provider list identifies individuals and entities that are excluded from Medicare reimbursement. In addition, the list includes the provider's specialty, notice date, and the end of the sanction period. The OIG also lists individuals and entities that have been reinstated to the Medicare Program. The OIG sanctioned provider list is available at www.oig.hhs.gov on the Internet. Once at this address, click on "Exclusions Database."

Government Services Administration (GSA) List of Excluded Providers

The GSA was established by the Federal Property and Administrative Services Act. Its role is to examine ways to improve the administrative services of the Federal Government. The GSA debarment, exclusion, and suspension lists for all Federal agencies are available at <http://epls.arnet.gov> on the Internet. This Web site assists Medicare and Medicaid contractors in verifying the eligibility of healthcare providers and/or entities seeking to participate in the Medicare and Medicaid Programs. CMS encourages individuals and entities to research the information on this Web site before adding a provider to a physician group or medical staff, purchasing or considering involvement in a medical facility or other entity that may seek payment from the Medicare Program.

Corporate Integrity Agreements

Healthcare providers are not required by law to have a formal compliance program in place. However, as part of their sentencing in a criminal prosecution or as part of a settlement agreement or civil prosecution, a healthcare provider may be required to enter into a corporate integrity agreement with the federal government. These agreements essentially mirror the structure of a compliance program, but may be more stringent. In addition, corporate integrity agreements are developed, imposed and monitored by the Federal Government (i.e., law enforcement). Healthcare providers who enter into

corporate integrity agreements with the federal government may also be subject to further review or investigation; consequences for not complying with a corporate integrity agreement may result in punitive actions such as prosecution or sanctions.

Chapter 11 - LEGISLATIVE ISSUES AFFECTING MEDICARE

This chapter discusses various federal laws that affect Medicare coverage and requirements for physicians, and other providers or suppliers who do business with Medicare.

Clinical Laboratory Improvement Amendments

The Clinical Laboratory Improvement Amendments (CLIA), passed by Congress in 1988, established quality standards for all laboratory testing. CLIA ensures the accuracy, reliability, and timeliness of patient test results, wherever a test is performed. A laboratory is defined as any facility that performs laboratory testing on specimens derived from humans for the purpose of providing information for the diagnosis, prevention, treatment of disease, or impairment of, or assessment of health. CLIA is user-fee funded; therefore, all costs of administering the program are covered by the regulated facilities.

CLIA standards are national and are not Medicare-exclusive. CLIA applies to all providers rendering clinical laboratory and certain other diagnostic services, whether or not claims are filed to Medicare.

CLIA Quality Standards

CLIA defines quality standards for proficiency testing (PT), patient test management, quality control, personnel qualifications, and quality assurance, as well as specific cytology provisions.

The Centers for Medicare & Medicaid Services (CMS) administers CLIA, including laboratory registration, fee collection, surveys, surveyor guidelines and training, enforcement, approvals of PT providers, accrediting organizations, and exempt states. The Centers for Disease Control and Prevention (CDC) are responsible for test categorization and CLIA studies.

CLIA Certificates

Five types of certificates may be issued to providers, who perform waived, moderate, or high complexity tests and procedures:

- *Certificate of waiver* – Issued to a laboratory to perform only waived tests (i.e., simple examinations or procedures that use methodologies that are so simple and accurate that the likelihood of erroneous results is negligible and poses no reasonable risk of harm to the patient if the test is performed incorrectly).
- *Certificate for Provider-Performed Microscopy Procedures (PPMP)* – Issued to a laboratory in which a physician, midlevel practitioner or dentist performs no tests other than the microscopy procedure (a procedure categorized as moderately complex where the primary instrument for performing the test is a microscope). This certificate permits the laboratory to also perform waived tests.
- *Certificate of registration* – Issued to a laboratory that enables the entity to conduct moderate or high complexity laboratory testing or both until the entity is determined by survey to be in compliance with the CLIA regulations.
- *Certificate of compliance* – Issued to a laboratory after an inspection that finds the laboratory to be in compliance with all applicable CLIA requirements.
- *Certificate of accreditation* – Issued to a laboratory on the basis of the laboratory's accreditation organization approved by CMS.

CLIA Number

Upon certification, each laboratory is assigned an individual and unique CLIA number. Each CLIA number consists of ten alphanumeric positions.

The CLIA number must be on all claims for laboratory services, or the claim will be returned as unprocessable. The CLIA number must be entered in block 23 of Form CMS-1500 or the applicable electronic field.

Guidelines for Teaching Physicians

Effective November 22, 2002, CMS implemented revised guidelines for teaching physicians and nonresident physicians who involve residents in patient care.

The guidelines require the presence of a teaching physician during the key portion of the service in which a resident is involved and for which contractor payment will be sought. These services must be identified using the GC modifier. Using this modifier certifies the teaching physician was present during the key portion of the service, and was immediately available during other parts of the service.

Medicare will pay for physician services furnished in teaching settings under the physician fee schedule only if:

- The services are personally furnished by a physician who is not a resident.
- A teaching physician was physically present during the critical or key portion(s) of the service that a resident performs, and the teaching physician participated in the management of the patient.
- A teaching physician provides care with a graduate medical education (GME) program that has been granted a primary care exception.

Any billable service performed by a student (other than the review of systems and/or past, family, or social history which are taken as part of an evaluation and management [E/M] service) must be performed in the physical presence of a teaching physician or a resident in a service meeting the requirements for teaching physician billing, as set forth in section 15016 of the Medicare Carriers Manual.

Students may document services in the medical record. However, the documentation of an E/M service by a student, to which a teaching physician may refer, is limited to documentation related to the review of systems and/or past, family, or social history. The teaching physician may not refer to a student's documentation of physical examination findings or medical decision making in his or her personal note. If the medical student documents E/M services, the teaching physician must verify and repeat documentation of the physical examination and medical decision making activities of the service.

Following are three common scenarios for teaching physicians providing E/M services:

1. The teaching physician personally performs all the required elements of an E/M service without a resident. In this scenario, the resident may or may not have performed the E/M service independently.
 - In the absence of a note by a resident, the teaching physician must document the E/M service as if in a non-teaching setting.
 - Where a resident has written notes, *the teaching physician's note may reference the resident's note*. The teaching physician must document that he or she performed the

critical or key portion(s) of the service and that he or she was directly involved in the management of the patient. The composite of the teaching physician's entry and the resident's entry together must support the medical necessity and level of service billed by the teaching physician.

2. The resident performs the elements required for an E/M service in the presence of, or jointly with, the teaching physician and the resident documents the service. In this case, the teaching physician must document that he or she was present during the performance of the critical or key portion(s) of the service and that he or she was directly involved in the management of the patient. *The teaching physician's note should reference the resident's note.* The composite of the teaching physician's entry and the resident's entry together must support the medical necessity and level of service billed by the teaching physician.
3. The resident performs some or all of the elements of the service in the absence of the teaching physician and documents his or her service. The teaching physician independently performs the critical or key portion(s) of the service with or without the resident present and, as appropriate, discusses the case with the resident. In this instance, the teaching physician must document that he or she personally saw the patient, personally performed critical or key portion(s) of the service, and participated in the management of the patient. *The teaching physician's note should reference the resident's note.* The composite of the teaching physician's entry and the resident's entry together must support the medical necessity of the billed service and the level of the service billed by the teaching physician.

Note: Documentation by the resident of the presence and participation of the teaching physician is not sufficient to establish the presence and participation of the teaching physician.

Exception for Certain Primary Care Centers

In certain situations, Medicare will pay teaching physician claims for services furnished by residents without the presence of a teaching physician. When a GME program of a primary care center is granted this exception, it applies to the following lower and mid-level evaluation and management services:

New Patient	Established Patient
99201	99211
99202	99212
99203	99213

For this exception to apply, GME programs must attest in writing that all of the conditions outlined in section 15016 of the Medicare Carriers Manual are met for a particular residency program. Centers exercising the primary care exception must maintain records demonstrating they qualify for the exception. Services billed under this exception must be identified using the *GE* modifier.

Mandatory Claims Filing Requirements

The Omnibus Budget Reconciliation Act of 1989 (OBRA) requires providers to submit claims for all services rendered to Medicare patients on or after September 1, 1990. This mandate applies to all physicians and suppliers who provide covered services to Medicare beneficiaries. However, it does not require providers to accept assignment. Also, providers may not charge patients for preparing or filing Medicare claims.

Medicare carriers monitor compliance with the mandatory claims filing requirement. Offenders may be subject to a civil monetary penalty of up to \$10,000 for each violation.

Exceptions to Mandatory Filing

Providers are not required to file claims on behalf of Medicare beneficiaries for:

- Used durable medical equipment (DME) purchased from a private source
- Services for which Medicare is secondary payer, but not enough information is available to process the claim
- Claims for services rendered outside the United States
- Services billed to third-party insurers (indirect payment provisions)
- Other unusual services, on a case-by-case basis

A physician is not required to file claims on behalf of a Medicare beneficiary when the physician has opted out of the Medicare Program by signing a private contract with the beneficiary.

Note: Providers are not required to file claims for excluded Medicare services; however, they are encouraged to do so, since many Medicare supplemental insurance policies pay for services that Medicare does not cover. These companies usually require a denial notice from Medicare prior to providing reimbursement.

If a provider does not accept assignment on a Medicare claim, the Privacy Act prohibits the carrier from releasing any claim information to the provider, except the following:

- Whether the claim has been received,
- Whether the claim has been paid, and/or
- The claim's status in the Medicare processing system.

More specific information may not be released, unless the patient authorizes its release. Limited status of nonassigned claims and complete status of assigned claims may be obtained through the local Medicare carrier.

Private Contracting with Medicare Beneficiaries

The Balanced Budget Act (BBA), Section 4507, allows certain physicians and practitioners (under a limited definition for this purpose) to privately contract with Medicare beneficiaries. To validate the contract, the physician or practitioner files an affidavit with Medicare, opting out of Medicare for two years.

These provisions allow physicians or practitioners to sign private contracts with Medicare beneficiaries. The physician must agree not to file claims to Medicare or any other organization that receives reimbursement from Medicare, unless the service is for emergency or urgent care. This situation requires the use of modifier GJ ("OPT-OUT" physician or practitioner emergency or urgent service).

Contracts written by the physician must be signed by the beneficiary before any item or service is provided (pursuant to the contract), and the contract must clearly indicate to the beneficiary that by signing the contract he or she:

- Agrees not to submit a claim to Medicare.
- Agrees to pay the physician for the service.
- Agrees to pay the "full-fee" for the service with no limits on amount.

- Acknowledges that supplemental insurance may not make payment because Medicare will not make payment.
- Acknowledges that they may go to another physician whom Medicare will reimburse for the services.

The contract must clearly indicate whether the physician is excluded from Medicare. The physician must file an affidavit with the Medicare contractor acknowledging that he or she will not file any claims with Medicare for two years, beginning on the date the affidavit was signed.

Physicians who violate any provision will not be allowed to enter into additional private contracts during the two-year period, nor may they anticipate reimbursement from Medicare for their services.

Anti-Fraud Provisions

False Claims Act

The False Claims Act prohibits the following:

- Knowingly filing a false or fraudulent claim to the government for payment
- Knowingly using a false record or statement to obtain payment on a false or fraudulent claim paid by the government
- Conspiring to defraud the government by getting a false or fraudulent claim allowed or paid

Note: Additional information may be found in 31 United States Code (U.S.C.) section 3729(a) of the Act.

Anti-Kickback Statute

The anti-kickback statute *prohibits* offering, soliciting, paying, or receiving remuneration for *referrals* of Medicare or Medicaid patients, or for referrals for services or items paid for, in whole or in part, by Medicare or Medicaid.

Additionally, the Anti-Kickback Statute *prohibits* offering, soliciting, paying, or receiving remuneration in return for *purchasing, leasing, ordering, arranging for, or recommending* purchasing, leasing, or ordering any goods, facility, service, or item for which payment may be made in whole or in part, by Medicare or Medicaid.

Discounts, rebates, or other reductions in price *may* violate the anti-kickback statute because such arrangements induce the purchase of items or services payable by Medicare or Medicaid. However, certain arrangements are permissible if they fall under a *safe harbor* provision.

Physician Self-Referral (Stark II) Laws

Since January 1995, the Social Security Act, Section 1877 (42 U.S.C. section 1395nn) prohibits physicians from making self-referrals for certain designated health services (DHS) involving the Medicare and Medicaid Programs. DHS includes the following items and services:

- Clinical laboratory services
- Physical therapy services
- Occupational therapy services
- Radiology services
- Radiation therapy services and supplies

- Durable medical equipment and supplies
- Parenteral and enteral nutrients, equipment, and supplies
- Prosthetic and orthotic devices and supplies
- Home health services
- Outpatient prescription drugs
- Inpatient/outpatient hospital services

The law also prohibits a physician or his or her immediate family from having a financial relationship with an entity to which Medicare patients are referred to receive a designated health service. A financial relationship may exist in the form of an ownership, investment interest, or compensation arrangement.

Penalties for Violations of the Law

The civil monetary penalty is a maximum of \$15,000 for each service billed or furnished as the result of a prohibited referral. A total maximum penalty of \$100,000 can be applied for each scheme to evade the requirement.

Safe Harbors

The Department of Health and Human Services (DHHS) established Safe Harbors for Protecting Health Plans as part of the Medicare and Medicaid Patient and Program Protection Act of 1987.

Safe harbors protect certain individuals, providers, or entities from criminal prosecution and/or civil sanctions (when certain requirements are met) for actions that appear to be unlawful or inappropriate according to Medicare law. They include:

- Protection to enrollees for certain incentives (including waiver of coinsurance and deductible amounts) paid by healthcare plans.
- Protection for certain negotiated price reduction agreements between healthcare plans and contract healthcare providers.

Safe harbors are updated annually to consider changes to medical delivery systems and new financial relationships.

Health Insurance Portability and Accountability Act

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) also known as the Kennedy-Kasselbaum bill, was enacted on August 21, 1996. Among other provisions, the Act is designed to protect health insurance coverage for workers and their families when they change or lose their jobs. The Act also imposes significant changes to anti-fraud and abuse activities.

HIPAA includes provisions designed to save money for healthcare businesses by encouraging electronic transactions, but it also requires new safeguards to protect the security and confidentiality of that information. The law gave Congress until August 21, 1999, to pass comprehensive health privacy legislation. When Congress did not enact such legislation after three years, the law required the DHHS to craft such protections by regulation.

The HIPAA Privacy Rule, Standards for Privacy of Individually Identifiable Health Information, took effect on April 14, 2001. As required by law, covered entities (health plans, healthcare clearinghouses, and healthcare providers who conduct certain financial and administrative transactions electronically) have until April 14, 2003, to comply with the final rule's provisions, except for small health plans that have until April 14, 2004, to comply. All medical records and other individually

identifiable health information used or disclosed by a covered entity in any form, whether electronically, on paper, or orally, are covered by the final rule.

Under the final rule, patients will have significant new rights to understand and control how their health information is used. As required by the HIPAA law itself, stronger state laws continue to apply. These confidentiality protections are cumulative; the final rule will set a national “floor” of privacy standards, but in some states individuals will have additional protections.

The final rule will be enforced by the DHHS Office for Civil Rights (OCR). OCR will provide assistance and guidance to covered entities in meeting the requirements of the HIPAA Privacy Rule. Additional information is available at www.hhs.gov/ocr/hipaa on the Internet.

Balanced Budget Act of 1997

The BBA of 1997 changed various aspects of the Social Security Act, including anti-fraud and abuse provisions and improvements to protect program integrity.

Permanent Exclusions

Medicare and state healthcare programs will exclude for at least 10 years an individual convicted on one previous occasion of one or more healthcare related crimes for which a mandatory exclusion could be imposed. Examples of such offenses are Medicare and state healthcare program-related crimes, patient abuse, or felonies related to healthcare fraud or controlled substances. Individuals who have been convicted on two or more previous occasions of such crimes are permanently excluded.

Authority to Refuse to Enter Into Agreements

The DHHS is authorized to:

- Refuse to enter into or renew an agreement.
- Terminate an agreement with a provider, if the provider has been convicted of a felony under federal or State law for an offense that DHHS determines is inconsistent with the best interests of the program or program beneficiaries.

Exclusion of Entity Controlled by Family Member

The DHHS is authorized to exclude from Medicare or any State healthcare program entities where a person transfers ownership or control to an immediate family member or household member, in anticipation of or following a conviction, assessment, or exclusion.

Imposition of Civil Monetary Penalties

Civil monetary penalties of up to \$10,000 are enforced when a person arranges or contracts for the provision of items or services with an individual or entity he or she knows or should know is excluded from a federal healthcare program. The individual or entity is also subject to an assessment of up to three times the amount claimed and to exclusion from federal healthcare programs.

A civil monetary penalty of up to \$50,000 plus up to three times the amount of remuneration offered, paid, solicited, or received can be levied for each violation of the anti-kickback statute.

Anti-Fraud Message in Medicare Handbook

The *Medicare & You Handbook* for beneficiaries contains the following:

- A statement indicating that errors occur and that Medicare fraud, waste, and abuse are a significant problem.

- A statement encouraging beneficiaries to review their Medicare summary notices or statements for accuracy and to report any errors or questionable charges.
- A description of the beneficiary's right to request an itemized statement from his or her provider for Medicare items and services.
- A description of the beneficiary Incentive Reward Program established under HIPAA.
- A DHHS OIG toll-free hotline number for fraud, waste, and abuse complaints and information.

Disclosure of Information and Surety Bonds

Durable medical equipment (DME) suppliers are required to disclose the identity of each person with an ownership or controlling interest in the supplier or any subcontractor in which the supplier has a direct or indirect ownership interest of five percent or more.

DME suppliers, home health agencies (HHAs), comprehensive outpatient rehabilitation facilities (CORFs), and rehabilitation agencies are required to post a surety bond of at least \$50,000.

Beneficiary Right to Itemized Statements

Medicare beneficiaries have the right to submit a written request to a physician or supplier for an itemized statement of any Medicare item or service received. The physician or supplier must furnish the itemized statement within 30 days of the request. Failure to provide the statement on time can result in a civil monetary penalty of up to \$100.00 for each occurrence. Medicare prohibits providers from charging beneficiaries for itemized statements.

APPENDIX

ACKNOWLEDGEMENTS

CMS acknowledges the excerpts provided by the following published resource materials:

PUBLISHED REFERENCE MATERIALS

American Medical Association, *Current Procedural Terminology CPT 2003*, Chicago, Ill., 2003

American Medical Association, *International Classification of Diseases 9th Revision Clinical Modification ICD-9-CM Professional Code Book 2003*, Chicago, Ill., 2003

U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, *Medicare Carriers Manual, Part III*

U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, *Medicare Coverage Issues Manual*

U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, *Medicare Part A Intermediary Manual*

U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, *Medicare & You 2003*, U.S. Government Printing Office, 2003

RESOURCES

The following resources are available to physicians by mail order, telephone, and the Internet.

Publications

The Current Procedural Terminology (CPT) book is a listing of descriptive terms and identifying codes for recording medical services and procedures performed by physicians and is effective for the current year.

Level I – CPT Book

American Medical Association
1-800-621-8335
www.amapress.org

The Healthcare Common Procedure Coding System (HCPCS) book contains national codes for recording medical services and procedures performed by physicians and is effective for the current year.

Level II – HCPCS Book

American Medical Association
1-800-621-8335
www.amapress.org

The International Classification of Diseases, 9th Revision, Clinical Management (ICD-9-CM) book contains diagnosis codes effective for the current year.

ICD-9-CM Diagnosis Coding Book

American Medical Association
1-800-621-8335
www.amapress.org

Note: Medicare carriers annually update CPT and HCPCS codes within the Medicare processing system. These changes are effective each year on January 1, and have a 90-day grace period (through March 30). ICD-9-CM codes are also updated annually and become effective October 1 each year.

Correct Coding Initiative (CCI)

The Centers for Medicare & Medicaid Services (CMS) has designated National Technical Information Services (NTIS) to publish CCI information. Subscriptions and single issues in various formats, including CD-ROM, are available. Contact NTIS for subscription or purchase information at:

Web site	www.ntis.gov/products/families/ci
Email	helpdesk@fedworld.gov
Telephone	1-800-363-2068 (or 703-605-6060 in Washington, D.C. area)
Mailing address	NTIS Subscriptions Department 5285 Port Royal Road Springfield, VA 22161

Medicare Part A and B Publications

All contractors are required to publish Medicare changes, local policy, and fee schedule updates on a regular basis. All of these publications may be obtained by contacting your local Medicare Carrier.

- Local Medicare Carrier toll-free customer service phone numbers offer service representatives that can provide clear answers to billing questions. A complete listing may be found at www.cms.hhs.gov/medlearn/tollnums.asp on the Internet.

The Commerce Clearing House Guide to Medicare and Medicaid (CCH)

The CCH, Medicare and Medicaid Guide, is a complete resource for healthcare professionals and suppliers of health services. It provides researchers with shortcuts to key information and quick access to research tools such as *Rapid Finder for Health Law*. This publication is available on CD-ROM and may be downloaded from the Internet. More information is available at:

Web site	www.cch.com
Telephone	1-800-835-5224
Mailing address	Commerce Clearing House, Inc 4025 West Peterson Ave. Chicago, IL 60646

Web Sites

Free Medicare Education

CMS offers Medicare education for all Medicare physicians and staff. Free, downloadable, Web-based courses are available at www.cms.gov/medlearn/cbts.asp on the Internet. Other free educational items such as VHS tapes and CD-ROMs are available at www.cms.hhs.gov/medlearn on the Internet.

Additionally, education is available by satellite broadcast. For a list of available topics, times, and host site locations, go to www.cms.hhs.gov/medlearn/broadcast.asp on the Internet.

Provider Enrollment

Enrollment information for suppliers and providers of Medicare services including forms and instructions on how to complete the forms are available at www.cms.hhs.gov/providers/enrollment on the Internet.

Quality of Care

CMS is committed to improving the health and satisfaction of all beneficiaries through an integrated quality improvement program. Information on many quality improvement initiatives is available at www.cms.hhs.gov/quality on the Internet.

Medicare Premium Amounts for 2003

This information is available at the Medicare Web site at www.medicare.gov on the Internet.

DME Claims

Claims for supplies, orthotics, prosthetics, equipment, and certain injectables are submitted to the Durable Medical Equipment Regional Carrier (DMERC). A list of DMERCs can be found at the following Web site at www.cms.hhs.gov/contacts/incardir.asp on the Internet.

Form CMS-1500

Form CMS-1500 (for physician and supplier services) and other forms are available in various formats from the U.S. Government Printing Office (GPO). The GPO may be contacted for purchase information at:

Web site <http://bookstore.gpo.gov>
Telephone 1-866-512-1800
Mailing address Superintendent of Documents
P.O. Box 371954
Pittsburgh, PA 15250-7954

Reporting Fraud and Abuse

To ask questions about fraud and abuse or to report suspected fraudulent or abusive activities, physicians are encouraged to contact their Medicare contractor or the national Office of the Inspector General (OIG) at the Department of Health and Human Services (DHHS):

Web site <http://oig.hhs.gov/>
Email HHTips@oig.dhhs.gov
Telephone 1-800-HHS-TIPS (1-800-447-8477) TTY (for the deaf): 1-800-377-4950
Facsimile 1-800-223-8164
Mailing address Office of Inspector General
Department of Health and Human Services
Attn: HOTLINE
330 Independence Ave., SW
Washington, D.C. 20201

Sanction Provider Lists

The Government Services Administration (GSA) debarment, exclusion, and suspension lists for all federal agencies are available on the Internet. Go to: <http://epls.arnet.gov> and click on "EPLS Reports Menu." This Web site will assist Medicare and Medicaid contractors in verifying the eligibility of healthcare providers and entities seeking to participate in the Medicare and Medicaid Programs.

The DHHS/OIG sanctioned provider list is at <http://exclusions.oig.hhs.gov> on the Internet.

The documents issued by the OIG on compliance program guidance are published in the Federal Register and are at <http://oig.hhs.gov/modcomp/index.htm> on the Internet.

FORMS

Form CMS-1500 – Medicare Part B claim form (Page 149)

Form CMS-1450 (UB-92) – Medicare Part A claim form (Page 151)

Form CMS-460 – Medicare Participating Physician or Supplier Agreement (Page 153)

Form CMS-R-131-G – Advance Beneficiary Notice (Page 155)

Note: The following forms are provided as samples only and should not be reproduced or used as originals. More information on the above listed forms can be obtained from the CMS Web site at www.cms.hhs.gov/forms on the Internet.

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(APPROVED BY AMA COUNCIL ON MEDICAL SERVICES 8/88)

PLEASE PRINT OR TYPE

 APPROVED CMB-0838-0008 FORM CMB-1500 (12-90), FORM RRB-1500,
 APPROVED CMB-1215-0055 FORM CWCOP-1500, APPROVED CMB-0720-0001 (CHAMPUS)

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly file a statement of claim containing any misrepresentation or any false, in complete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services Information on the patient's sponsor should be provided in those items captioned in "Insured", i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either a civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a)(6), and 44 USC 3101, 41 CFR 101 et seq and 10 USC 1079 and 1086, 5 USC 8101 et seq, and 30 USC 901 et seq; 38 USC 613, E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, "Carrier Medicare Claims Record," published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA, to the Dept. of Justice for representation of the Secretary of Defense in civil actions, to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1129B of the Social Security Act and 31 USC 3901-3912 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0008. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, N2-14-26, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

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UNIFORM BILL:

NOTICE: ANYONE WHO MISREPRESENTS OR FALSIFIES ESSENTIAL INFORMATION REQUESTED BY THIS FORM MAY UPON CONVICTION BE SUBJECT TO FINE AND IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW.

Certifications relevant to the Bill and Information Shown on the Face Hereof: Signatures on the face hereof incorporate the following certifications or verifications where pertinent to this Bill

1. If third party benefits are indicated as being assigned or in participation status, on the face thereof, appropriate assignments by the insured/beneficiary and signature of patient or parent or legal guardian covering authorization to release information are on file. Determinations as to the release of medical and financial information should be guided by the particular terms of the release forms that were executed by the patient or the patient's legal representative. The hospital agrees to save harmless, indemnify and defend any insurer who makes payment in reliance upon this certification, from and against any claim to the insurance proceeds when in fact no valid assignment of benefits to the hospital was made.
2. If patient occupied a private room or required private nursing for medical necessity, any required certifications are on file.
3. Physician's certifications and re-certifications, if required by contract or Federal regulations, are on file.
4. For Christian Science Sanatoriums, verifications and if necessary re-verifications of the patient's need for sanatorium services are on file.
5. Signature of patient or his/her representative on certifications, authorization to release information, and payment request, as required by Federal law and regulations (42 USC 1935f, 42 CFR 424.36, 10 USC 1071 thru 1086, 32 CFR 199) and, any other applicable contract regulations, is on file.
6. This claim, to the best of my knowledge, is correct and complete and is in conformance with the Civil Rights Act of 1964 as amended. Records adequately disclosing services will be maintained and necessary information will be furnished to such governmental agencies as required by applicable law.
7. For Medicare purposes:

If the patient has indicated that other health insurance or a state medical assistance agency will pay part of his/her medical expenses and he/she wants information about his/her claim released to them upon their request, necessary authorization is on file. The patient's signature on the provider's request to bill Medicare authorizes any holder of medical and non-medical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, workers' compensation, or other insurance which is responsible to pay for the services for which this Medicare claim is made.

8. For Medicaid purposes:

This is to certify that the foregoing information is true, accurate, and complete.

I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State Laws.

9. For CHAMPUS purposes

This is to certify that

- (a) the information submitted as part of this claim is true, accurate and complete, and, the services shown on this form were medically indicated and necessary for the health of the patient,
- (b) the patient has represented that by a reported residential address outside a military treatment center catchment area he or she does not live within a catchment area of a U.S. military or U.S. Public Health Service medical facility, or if the patient resides within a catchment area of such a facility, a copy of a Non-Availability Statement (DD Form 1251) is on file, or the physician has certified to a medical emergency in any assistance where a copy of a Non-Availability Statement is not on file,
- (c) the patient or the patient's parent or guardian has responded directly to the provider's request to identify all health insurance coverages, and that all such coverages are identified on the face the claim except those that are exclusively supplemental payments to CHAMPUS-determined benefits,
- (d) the amount billed to CHAMPUS has been billed after all such coverages have been billed and paid, excluding Medicaid, and the amount billed to CHAMPUS is that remaining claimed against CHAMPUS benefits,
- (e) the beneficiary's cost share has not been waived by consent or failure to exercise generally accepted billing and collection efforts, and,
- (f) any hospital-based physician under contract, the cost of whose services are allocated in the charges included in this bill, is not an employee or member of the Uniformed Services. For purposes of this certification, an employee of the Uniformed Services is an employee, appointed in civil service (refer to 5 USC 2105), including part-time or intermittent but excluding contract surgeons or other personnel employed by the Uniformed Services through personal service contracts. Similarly, member of the Uniformed Services does not apply to reserve members of the Uniformed Services not on active duty
- (g) based on the Consolidated Omnibus Budget Reconciliation Act of 1986, all providers participating in Medicare must also participate in CHAMPUS for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987
- (h) if CHAMPUS benefits are to be paid in a participating status, I agree to submit this claim to the appropriate CHAMPUS claims processor as a participating provider. I agree to accept the CHAMPUS-determined reasonable charge as the total charge for the medical services or supplies listed on the claim form. I will accept the CHAMPUS-determined reasonable charge even if it is less than the billed amount, and also agree to accept the amount paid by CHAMPUS, combined with the cost-share amount and deductible amount, if any, paid by or on behalf of the patient as full payment for the listed medical services or supplies. I will make no attempt to collect from the patient (or his or her parent or guardian) amounts over the CHAMPUS-determined reasonable charge. CHAMPUS will make any benefits payable directly to me, if I submit this claim as a participating provider

ESTIMATED CONTRACT BENEFITS

OMB No. 0938-0373

MEDICARE
PARTICIPATING PHYSICIAN OR SUPPLIER AGREEMENT

Name(s) and Address of Participant*Physician or Supplier
Identification Code(s)*

The above named person or organization, called "the participant," hereby enters into an agreement with the Medicare program to accept assignment of the Medicare Part B payment for all services for which the participant is eligible to accept assignment under the Medicare law and regulations and which are furnished while this agreement is in effect.

1. Meaning of Assignment - For purposes of this agreement, accepting assignment of the Medicare Part B payment means requesting direct Part B payment from the Medicare program. Under an assignment, the approved charge, determined by the Medicare carrier, shall be the full charge for the service covered under Part B. The participant shall not collect from the beneficiary or other person or organization for covered services more than the applicable deductible and coinsurance.

2. Effective Date - If the participant files the agreement with any Medicare carrier during the enrollment period, the agreement becomes effective _____.

3. Term and Termination of Agreement - This agreement shall continue in effect through December 31 following the date the agreement becomes effective and shall be renewed automatically for each 12-month period January 1 through December 31 thereafter unless one of the following occurs:

a. During the enrollment period provided near the end of any calendar year, the participant notifies in writing every Medicare carrier with whom the participant has filed the agreement or a copy of the agreement that the participant wishes to terminate the agreement at the end of the current term. In the event such notification is mailed or delivered during the enrollment period provided near the end of any calendar year, the agreement shall end on December 31 of that year.

b. The Centers for Medicare & Medicaid Services may find, after notice to and opportunity for a hearing for the participant, that the participant has substantially failed to comply with the agreement. In the event such a finding is made, the Centers for Medicare & Medicaid Services will notify the participant in writing that the agreement will be terminated at a time designated in the notice. Civil and criminal penalties may also be imposed for violation of the agreement.

Signature of participant
(or authorized representative
of participating organization)

Title
(if signer is authorized
representative of organization)

Date

(including area code)
Office phone number

*List all names and identification codes under which the participant files claims with the carrier with whom this agreement is being filed.

CMS-460 (10/02)

2

Received by
(name of carrier)

Effective date

Initials of carrier official

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0373. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1830.

Patient's Name: _____

Medicare # (HICN): _____

ADVANCE BENEFICIARY NOTICE (ABN)

NOTE: You need to make a choice about receiving these health care items or services.

We expect that Medicare will not pay for the item(s) or service(s) that are described below. Medicare does not pay for all of your health care costs. Medicare only pays for covered items and services when Medicare rules are met. The fact that Medicare may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Right now, in your case, **Medicare probably will not pay for –**

Items or Services:

Because:

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should **read this entire notice carefully.**

- Ask us to explain, if you don't understand why Medicare probably won't pay.
- Ask us how much these items or services will cost you (**Estimated Cost: \$** _____), in case you have to pay for them yourself or through other insurance.

PLEASE CHOOSE ONE OPTION. CHECK ONE BOX. SIGN & DATE YOUR CHOICE.

☐ **Option 1. YES.** I want to receive these items or services.

I understand that Medicare will not decide whether to pay unless I receive these items or services. Please submit my claim to Medicare. I understand that you may bill me for items or services and that I may have to pay the bill while Medicare is making its decision. If Medicare does pay, you will refund to me any payments I made to you that are due to me. If Medicare denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal Medicare's decision.

☐ **Option 2. NO.** I have decided not to receive these items or services.

I will not receive these items or services. I understand that you will not be able to submit a claim to Medicare and that I will not be able to appeal your opinion that Medicare won't pay.

Date

Signature of patient or person acting on patient's behalf

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.

OMB Approval No. 0938-0566 Form No. CMS-R-131-G (June 2002)

GLOSSARY

A

Aberrancy – medical services that deviate from what is considered normal or typical when compared to the national average

ABN – advance beneficiary notice

abuse – abuse describes practices that either directly or indirectly, result in unnecessary costs to the Medicare Program. Many times abuse appears quite similar to fraud except that it is not possible to establish that abusive acts were committed knowingly, willfully, and intentionally. Although these types of practices may initially be categorized as *abusive* in nature, under certain circumstances they may develop into *fraud* if there is evidence the subject was knowingly and willfully conducting an abusive practice.

Act – usually refers to the Social Security Act

adjudication – process of determining whether a Medicare claim is paid

adjustment – additional payment or correction of records on a previously processed claim

administrative law judge (ALJ) – hears appeals of denied claims, as well as appeals from proposed OIG exclusions

admission – entry to a hospital or other healthcare institution as an inpatient

advance beneficiary notice (ABN) – written notification to a patient, before a service is rendered, that payment may be denied or reduced because the service may not be covered as medically reasonable and necessary

advanced registered nurse practitioner (ARNP) – registered nurse who has advanced education and clinical training in a health care specialty area

ALJ – administrative law judge

AMA – American Medical Association

ambulatory surgical center (ASC) – a freestanding facility, other than a hospital or physician's office, where outpatient surgical and diagnostic services are provided.

ancillary services – professional services provided by a hospital or other inpatient health program, other than room, board, and surgery (e.g., laboratory, X-ray, drugs)

American Medical Association (AMA) – a national association that develops and promotes medical practice, research, and education on behalf of patients and physicians.

appeal – an independent, critical examination of a claim made by carrier personnel not involved in the initial claim determination. A request for a review may be made to the local Medicare carrier by telephone or in writing. Physicians, beneficiaries or their representatives, providers or other suppliers, may request appeals or reviews.

appellant – individual who appeals a claim decision

approved charge – allowed amount based on the Medicare fee schedule or its transition rules; non-participating physician charges are subject to the limiting charge

ASC – ambulatory surgical center

assignment – physician, provider, or supplier agrees to accept the Medicare fee schedule amount as payment in full for all covered services and the beneficiary agrees to have services paid directly to the physician, provider, or supplier

audit – process to ensure that Medicare reimburses providers based only on costs associated with patient care

B

balance billing, excess charge – difference between billed amount and amount allowed by Medicare

Balanced Budget Act of 1997 (BBA) – law that changes sections of the Social Security Act, including several anti-fraud and abuse provisions and improvements to protect program integrity

barium enema – suspension of barium sulfate injected into the lower bowel to render it radiopaque, usually followed by injection of air to inflate the bowel and increase definition for the purposes of identifying disorders or early signs of cancer

BBA – Balanced Budget Act of 1997

BCBSA – Blue Cross Blue Shield Association

beneficiary – person eligible to receive Medicare or Medicaid payment and/or services

beneficiary impersonation – use of lost, stolen, or otherwise obtained Medicare identification to unlawfully procure Medicare benefits

benefit period – the measure of a Medicare beneficiary's use of hospital and skilled nursing facility services

billing service – company that, for a fee, furnishes billing, collection, and/or claim filing services for physicians and/or suppliers

Blue Cross Blue Shield Association (BCBSA) – nonprofit corporation representing the Blue Cross and Blue Shield plans on a national level as a coordinating agency in marketing, government relations, and other system wide initiatives; owns the Blue Cross Blue Shield mark and sets approval standards

bone mass measurements – radiologic or radioisotopic procedure or other procedure that identifies bone mass, detects bone loss, or determines bone quality

C

CAC – Carrier Advisory Committee

Carrier Advisory Committee (CAC) – a formal mechanism for physicians to be informed of and participate in the development of a Local Medical Review Process in an advisory capacity. This group also discusses ways to improve administrative policies that are within carrier discretion.

CAH – critical access hospital

calendar year (CY) – January 1 through December 31

capitation rate – fixed amount CMS pays to an approved managed care plan selected by an enrolled Medicare beneficiary

carrier – CMS contractor that determines reasonable charges, accuracy, and coverage for Medicare Part B services and processes Part B claims and payments

case management – arrangement of services needed to give proper healthcare to a beneficiary; tracking of beneficiary's use of facilities and resources

certified provider – physician, other individual, or entity meeting certain quality standards that provides outpatient self-management training services and other Medicare covered items and services

Centers for Medicare & Medicaid Services (CMS) – federal agency, part of DHHS; administers and oversees the Medicare Program and a portion of the state Medicaid Program. Responsibilities include managing contractor claims payment, fiscal audit and/or overpayment prevention and recov-

ery, and developing and monitoring payment safeguards necessary to detect and respond to payment errors or abusive patterns of service delivery.

CHAMPUS (TRICARE) – the healthcare program for active duty members of the military, military retirees, and their eligible dependents. TRICARE was formerly known as CHAMPUS (Civilian Health and Medical Program of the Uniformed Services).

claim – request for payment of Medicare benefits or services rendered by a provider or received by a beneficiary

clearinghouse – an organization, usually national, that, for a fee, receives and sorts provider claims and forwards them to the correct Medicare contractor or commercial insurer.

CLIA – Clinical Laboratory Improvement Amendments

Clinical Laboratory Improvement Amendments (CLIA) – 1988 legislation that set quality and performance standards for all laboratory testing. CLIA standards are national and are not Medicare-exclusive. CLIA applies to all providers rendering clinical laboratory and certain other diagnostic services, whether or not claims are filed to Medicare.

CMHC – community mental health center

CMS – Centers for Medicare & Medicaid Services

coinsurance, copayment – amount that Medicare will not pay; the beneficiary or the beneficiary's supplemental insurance company is responsible for paying coinsurance to the physician

colonoscopy – endoscopic examination of the colon to identify disorders or early signs of cancer

colorectal cancer screening – various medical procedures or tests (see fecal occult blood test, sigmoidoscopy, colonoscopy, or barium enema) to identify disorders or early signs of cancer of the gastrointestinal tract

community mental health center (CMHC) – facility that provides outpatient mental health services to individuals residing within a specific geographic area

concurrent care – certain E/M services that are rendered by more than one physician with the same or similar specialty on the same date of service

consultation – examination by an additional physician or specialist, at the request of a referring physician, the patient, or the patient's family

contractor – state or private health insurer that processes Medicare claims and makes payments to providers of services and to beneficiaries. See also carrier, durable medical equipment regional contractor (DMERC), and intermediary

copayment – see coinsurance

covered services – reasonable and medically necessary services, rendered to Medicare or Medicaid patients, and reimbursable to the provider or beneficiary

CPT – Current Procedural Terminology

critical access hospital (CAH) – established as part of the BBA Medicare Rural Hospital Flexibility Program to replace the Essential Access Community and Rural Primary Care Hospital Programs

crossover claims – Medicare claims that are also covered by other insurance (e.g., Medigap, private insurance)

Current Procedural Terminology (CPT) – system of uniform medical procedure codes to identify specific healthcare services performed; developed by the AMA and used by most insurers and providers for billing purposes

CY – calendar year

D

date of service – date a service was actually performed

deductible – amount a beneficiary must pay before Medicare begins to pay for covered services and supplies

Department of Health and Human Services (DHHS) – administers many of the federal “social” programs dealing with the health and welfare of citizens of the United States; parent agency of the Centers for Medicare & Medicaid Services (CMS)

DG – documentation guidelines

DHHS – Department of Health and Human Services

Diabetes self-management training – program that educates patients in the successful self-management of diabetes including education about treatment, diet, and exercise

diagnosis – identification of the patient’s condition, cause, or disease

diagnosis related group (DRG) – system that groups patients according to principal diagnosis, presence of a surgical procedure, age, presence or absence of significant complications, etc.

diagnostic examination – procedures used to discover the nature and underlying cause of an illness

digital rectal examination (DRE) – a clinical examination of an individual’s prostate for nodules or other abnormalities

DME – durable medical equipment

DMERC – durable medical equipment regional contractor

documentation guidelines (DG) – criteria used when preparing or reviewing documentation for an Evaluation and Management (E/M) service

DRG – diagnosis related group

duplicate claims – billing for the same service more than once; Medicare may remove physicians who repeatedly submit duplicate claims from the electronic billing network

durable medical equipment (DME) – reusable medical equipment ordered by a physician for use in a beneficiary’s home (e.g., walker, wheelchair, hospital bed)

durable medical equipment regional contractor (DMERC) – CMS contractor that provides Medicare claims processing and payment of DME, prosthetics, orthotics, and supplies for a designated region of the country

E

EFT – electronic funds transfer

electronic funds transfer (EFT) – electronic transfer of Medicare payments directly to a provider’s financial institution

electronic media claims (EMC) – transmission of claims via modem to the contractor, eliminating mailroom processing and manual data entry; payment is released when CMS time requirements are satisfied, resulting in a faster cash flow turnaround for providers

electronic remittance notice (ERN) – electronic summarized statement for providers, including payment information for one or more beneficiaries; equivalent to the Medicare remittance notice (MRN); see also Medicare remittance notice

eligible – qualified to receive benefits

eligibility date – starting date that benefits are available

EMC – electronic media claims

emergency – a situation in which a patient requires immediate medical intervention as a result of severe, life-threatening, or potentially disabling conditions

end-stage renal disease (ESRD) – kidney failure that is severe enough to require lifetime dialysis or a kidney transplant; ESRD patients are eligible for Social Security payments if found to be disabled
enrollment – the means by which a person establishes membership in a program or group
entitlement – state of meeting all of the requirements for a particular Medicare benefit; the date of entitlement begins at age 65 for most beneficiaries

ERN – electronic remittance notice

ESRD – end-stage renal disease

excess charge – see balance billing

exclusion – situation or condition where coverage is disallowed by a subscriber's contract; DHHS/OIG penalty imposed on a provider, prohibiting the individual from billing Medicare or other government programs

exclusion list, sanctioned provider list – OIG list of providers, individuals, and entities that are excluded from Medicare reimbursement; includes identifying information about the sanctioned party, specialty, notice date, sanction period, and sections of the Social Security Act used in arriving at the determination to impose a sanction

experimental, investigative – any treatment, procedure, equipment, drug, drug usage, device, or supply not generally recognized as accepted medical practice; includes services or supplies requiring federal or other government approval not granted at the time services were rendered

F

False Claims Act – federal legislation that prohibits knowingly filing a false or fraudulent claim to the government for payment, knowingly using a false record or statement to obtain payment on a false or fraudulent claim paid by the government, and conspiring to defraud the government by getting a false or fraudulent claim allowed or paid

fecal occult blood test – a guaiac-based test for peroxidase activity that the patient completes by taking samples from two different sites of three consecutive stools

Federal Employees Health Benefits (FEHB) Program – the largest private employer-sponsored healthcare program in the country, with about 300 participating health insurance plans and over 8.7 million federal employees, retirees, and dependents.

FEHB – Federal Employees Health Benefits Program

fee-for-service – payment system where providers are paid a specific amount for each service rendered

fee schedule, Medicare fee schedule (MFS) – complete list of medical procedure codes and the maximum dollar amounts Medicare will allow for each service rendered for a beneficiary. MFS is based on the calculation of several components, including relative value unit (RVU), which is based on three factors: the physician's work, overhead expenses, and malpractice insurance.

FI – fiscal intermediary

fiscal intermediary (FI) – CMS contractor that determines reasonable charges, accuracy, and coverage for Medicare Part A services and processes Part A claims and payments

fiscal year (FY) – October 1 through September 30, for Medicare Part A and B

fraud – Fraud is the intentional deception or misrepresentation that an individual knows to be false or does not believe to be true and makes, knowing that the deception could result in some unauthorized benefit to himself/herself or some other person.

FY – fiscal year

G

gaps, Medicare gaps – costs or services that are not covered under the Medicare plan

global fee – combined technical (equipment) and professional (physician) charges or payment

glaucoma screening –dilated eye examination with an intraocular pressure measurement and a direct ophthalmoscopy examination, or a slit-lamp biomicroscopic examination, to identify eye disorders or early signs of glaucoma

H

HCPCS – Healthcare Common Procedure Coding System

Healthcare Common Procedure Coding System (HCPCS) – uniform method for providers and suppliers to report professional services, procedures, and supplies. HCPCS includes CPT codes (Level I), national alphanumeric codes (Level II), and local codes (Level III) assigned and maintained by local Medicare contractors.

health insurance claim number (HIC/HICN) – unique alphanumeric Medicare entitlement number assigned to a Medicare beneficiary; appears on the Medicare card

Health Insurance Portability and Accountability Act of 1996 (HIPAA) – also known as the Kennedy-Kasselbaum bill enacted on August 21, 1996; designed to protect health insurance coverage for workers and their families when they change or lose their jobs; imposes significant changes to anti-fraud and abuse activities; includes provisions designed to save money for healthcare businesses by encouraging electronic transactions and requiring new safeguards to protect the security and confidentiality of patient health information.

health maintenance organization (HMO) – a form of health insurance combining a range of coverage on a group basis; a group of doctors and other medical professionals offer care through the HMO for a flat monthly rate with no deductibles; only visits to professionals within the HMO network are covered by the policy, all visits; prescriptions and other care must be cleared by the HMO in order to be covered.

health professional shortage area (HPSA) – medically under-served area of a state where physicians receive a ten percent bonus payment for all professional physician services (i.e., services subject to the Medicare physician fee schedule)

Hearing Officer hearing – independent determination related to claims where a party has appealed a review decision within six months of the date of notice of the decision; hearing is rendered by a hearing officer assigned by the contractor; amount in controversy must be at least \$100, which can include more than one claim

Hepatitis B vaccine – preparation of killed microorganisms, living attenuated organisms, or living fully virulent organisms that is administered to produce or artificially increase immunity to Hepatitis B

HHA – home health agency

HI – Medicare Part A; see Hospital Insurance

HICN – health insurance claim number

HIPAA – Health Insurance Portability and Accountability Act of 1996

HMO – health maintenance organization

HPSA – health professional shortage area

home health agency (HHA) – public or private organization that specializes in giving in-home skilled nursing and other therapeutic services, such as physical therapy

homebound – normally unable to leave home; leaving home takes considerable and taxing effort; patient may leave home for medical treatment or short, infrequent absences for nonmedical reasons, like a trip to the barber

home healthcare – part-time healthcare services provided in the home for the treatment of an illness or injury. Medicare pays for home care only if the type of care needed is skilled and required on an intermittent basis and is intended to help people recover or improve from an illness, not to provide unskilled services over a long period of time.

hospice – facility providing pain relief, symptom management, and supportive services to terminally ill people and their families; eligible beneficiary must have a life expectancy of six months or less

hospital – institution with organized medical staff, permanent facilities that include inpatient beds, medical services including physician services and continuous nursing services, to provide diagnosis and treatment for patients with a variety of medical conditions, both surgical and nonsurgical

hospital based physician – doctor of medicine or osteopathy, salaried or unsalaried, under contract or arrangement to provide services in a hospital setting, who renders treatment or services in the hospital environment

hospital, special – institution with organized medical staff, permanent facilities that include inpatient beds, medical services including physician services and continuous nursing services, to provide definitive diagnosis and treatment for patients with specific needs, including obstetrics, tuberculosis, psychiatry, physical medicine, rehabilitation, and similar specialized treatment

Hospital Insurance (HI) – also known as Medicare Part A under Title XVIII of the Social Security Act, coverage is generally provided automatically, and free of premiums, to persons age 65 or over who are eligible for Social Security or Railroad Retirement benefits, whether they have claimed the monthly cash benefits or not, also certain government employees and certain disabled individuals

hotline – providers and the public are encouraged to ask questions or to report suspected fraudulent or abusive activities; contact the local Medicare contractor or call the national DHHS/OIG hotline directly at: 1-800-HHS-TIPS

I

ICD-9-CM – International Classification of Diseases, 9th Revision, Clinical Modification; a national coding method to enable providers to effectively document the medical condition, symptom, or complaint that is the basis for rendering a specific service.

“incident to” services – services rendered by employees of physicians or physician-directed clinics, when the services provided are integral, though incidental, to the physician’s professional service and are performed under direct supervision of the physician

influenza vaccine – a preparation of killed microorganisms, living attenuated organisms, or living fully virulent organisms that is administered to produce or artificially increase immunity to influenza.

inpatient – individual who has been admitted at least overnight to a hospital or other health facility for the purpose of receiving a diagnosis, treatment, or other health service

interactive telecommunication systems – multimedia communications equipment that permits real-time communication between the distant site practitioner (i.e., where the expert physician or practitioner is located at the time the service is provided) and the patient

intermediary, fiscal intermediary (FI) – CMS contractor that determines reasonable charges, accuracy, and coverage for Medicare Part A services and processes Part A claims and payments

inquiry – written request for information, usually pertaining to claim status or general information, such as deductible or entitlement

investigative, experimental – any treatment, procedure, equipment, drug, drug usage, device, or supply not generally recognized as accepted medical practice; includes services or supplies requiring federal or other government approval not granted at the time services were rendered

J

judicial review – part of the Medicare appeal process; if at least \$1,000 remains in controversy following the Departmental Appeals Board decision, judicial review before a federal district court judge can be considered

K

kickback – offering, soliciting, paying, or receiving remuneration for *referrals* of Medicare or Medicaid patients, or for referrals for services or items paid for, in whole or in part, by Medicare or Medicaid; prohibited by Anti-Kickback Statute

L

licensed physician – physician who is authorized to perform services within limitations imposed by the state on the scope of practice; issuance by a state of a license to practice medicine constitutes legal authorization; see also physician

lifetime reserve days – the nonrenewable, one-time bank of 60 days that a Medicare patient is given to use when the covered days of a spell of illness are exhausted

limiting charge – maximum amount a nonparticipating physician may legally charge a Medicare patient for services billed on nonassigned claims

LMRP – local medical review policy

local medical review policy (LMRP) – formal statement developed through a specific process that defines a procedure or service and provides decision-making criteria for claim review and payment decisions

long-term care – custodial care given at home or in a nursing home for people with chronic disabilities and lengthy illnesses; not covered by Medicare

M

mammography screening – x-ray of examination of the breasts for early detection of cancer

managed care – system of providing healthcare that is designed to control costs through managed care programs in which the physician accepts constraints on the amount charged for medical care and the patient is limited in the choice of a physician (e.g., HMO, PPO)

Medicaid – Federal/State entitlement program under Title XIX of the Social Security Act that pays for medical assistance for certain individuals and families with low incomes and resources; policies for eligibility, services, and payment are complex and vary considerably, even among States of similar size or geographic proximity.

medical insurance, supplemental medical insurance (SMI) – also known as Medicare Part B under Title XVIII of the Social Security Act, provides insurance coverage for services by physicians and medical suppliers to persons age 65 or over who are eligible for Social Security or Railroad Retirement benefits, whether they have claimed the monthly cash benefits or not, also certain government employees and certain disabled individuals

MR – medical review

medical nutrition therapy – refers to specific nutritional procedures including assessment and interventions in the treatment of an illness, injury, or disease condition

medical review (MR) – review of services by contractor medical personnel; includes analysis of claims data to identify potential billing problems resulting in inappropriate utilization situations; includes various plans of action to correct the problem

medically necessary services – services or supplies that are proper and needed for the diagnosis or treatment of an illness or injury, meet standards of good medical practice, and are not provided for the convenience of the patient or the doctor

Medicare – a federal health insurance program established by Congress through Title XVIII of the Social Security Act (July 1, 1966) that provides medical coverage for people 65 or older, certain disabled individuals, and most individuals with end-stage renal disease (ESRD)

Medicare-certified provider – physician, other individual, or entity meeting certain quality standards that provides outpatient self-management training services and other Medicare covered items and services

Medicare + Choice – Part C of the Medicare Program; set of health care options created by BBA; “managed care” plan; includes HMO, POS, PSO, PPO, MSA, religious fraternal benefit society plan (RFP), private fee-for-service plan

Medicare Part A – also known as Hospital Insurance (HI); coverage that is generally provided automatically, and free of premiums, to persons age 65 or over who are eligible for Social Security or Railroad Retirement benefits, whether they have claimed the monthly cash benefits or not, also certain government employees and certain disabled individuals

Medicare Part B – also known as medical insurance or supplemental medical insurance (SMI); provides insurance coverage for services by physicians and medical suppliers to persons age 65 or over who are eligible for Social Security or Railroad Retirement benefits, whether they have claimed the monthly cash benefits or not, also certain government employees and certain disabled individuals

Medicare Part C – Part C of the Medicare Program; set of health care options created by BBA; “managed care” plan; includes HMO, POS, PSO, PPO, MSA, religious fraternal benefit society plan (RFP), private fee-for-service plan

Medicare remittance notice (MRN) – paper summarized statement for providers, including payment information for one or more beneficiaries; equivalent to the electronic remittance notice (ERN); see also electronic remittance notice (ERN)

Medicare Secondary Payer (MSP) – the term used when Medicare is not responsible for paying first on a claim; some individuals have other insurance or coverage that must pay before Medicare pays (e.g., Employer Group Health Plan)

Medicare Summary Notice (MSN) – statement sent to a Medicare beneficiary that indicates how Medicare processed the claim

Medicare trust funds – U.S. Department of Treasury accounts established by the Social Security Act for the receipt of revenues, maintenance of reserves, and disbursement of payments for Medicare Programs

Medigap – Medicare supplemental health insurance policies sold by private insurance companies and designed to supplement, or fill “gaps” in, Medicare coverage; such policies usually, but not always, feature coverage of copayments and deductibles

MEDPARD Directory – state and county directory that contains names, addresses, and specialties of Medicare participating physicians who have agreed to accept assignment on all Medicare claims and covered services

modifier – two-digit alphanumeric code used in conjunction with a procedure code to provide additional information about the service, may affect reimbursement of services

MRN – Medicare remittance notice

MSN – Medicare summary notice

MSP – Medicare Secondary Payer

N

nonassigned claim – type of claim that may only be filed by a nonparticipating Medicare physician; when a claim is filed nonassigned the beneficiary is reimbursed directly

nonparticipating physician – physician who does not agree to accept Medicare's allowed amount as payment in full and may charge the beneficiary, up to the limiting charge, for the service(s); may accept assignment of Medicare claims on a case-by-case basis

nonphysician practitioner – healthcare provider who meets state licensing requirements to provide specific medical services. Medicare allows payment for services furnished by nonphysician practitioners, including but not limited to advance registered nurse practitioners (ARNP), clinical nurse specialists (CNS), licensed clinical social workers (LCSW), physician assistants (PA), nurse midwives, physical therapists, and audiologists

normal/reasonable – applying normal collection processes to Medicare as well as non-Medicare patients

O

occupational therapy – various services and treatments provided to help a patient return to his or her usual activities of daily living (e.g., bathing, preparing meals, and housekeeping) after an illness or injury, either on an inpatient or outpatient basis

OCR – optical character recognition

Office of the Inspector General (OIG) – an organizational component of the Office of the Secretary, DHHS; responsible for conducting and supervising audits, investigations, and inspections relating to the programs and operations of DHHS, including Medicare and Medicaid. OIG provides leadership and coordination, recommends policies and corrective actions, prevents and detects fraud and abuse in DHHS programs and operations, and is responsible for all DHHS criminal investigations, including Medicare fraud, whether committed by contractors, grantees, beneficiaries, or providers of service.

OIG – Office of the Inspector General

open enrollment period – the one opportunity each year when physicians may change participation status for the following calendar year, usually in November

optical character recognition (OCR) – automated scanning process similar to scanners that read price labels in grocery stores; some contractors use OCR to scan claims information for further processing

outpatient – patient who receives care at a hospital or other health facility without being admitted to the facility; outpatient care also refers to care given in organized programs, such as outpatient clinics

overpayment – Medicare funds a physician, supplier or beneficiary has received in excess of amounts due and payable under Medicare statute and regulations; the amount of the overpayment is a debt owed to the United States Government

P

PA – physician assistant

Pap smear, Papanicolaou test – used for early detection of cancer and precancerous cellular changes

Part A – also known as hospital insurance (HI); coverage that is generally provided automatically, and free of premiums, to persons age 65 or over who are eligible for Social Security or Railroad Retirement benefits, whether they have claimed the monthly cash benefits or not, also certain government employees and certain disabled individuals

Part B – also known as medical insurance or supplemental medical insurance (SMI); provides insurance coverage for services by physicians and medical suppliers to persons age 65 or over who are eligible for Social Security or Railroad Retirement benefits, whether they have claimed the monthly cash benefits or not, also certain government employees and certain disabled individuals

Part C – Part C of the Medicare Program; set of health care options created by BBA; “managed care” plan; includes HMO, POS, PSO, PPO, MSA, religious fraternal benefit society plan (RFP), private fee-for-service plan

Participation Program – Medicare Program in which a physician voluntarily enters into an agreement to accept assignment for all services provided to Medicare patients

participating physician – physician who signs a participation agreement to accept assignment on all claims submitted to Medicare

patient – person under treatment or care, by a physician or surgeon, or in a hospital

physical therapy – treatment of injury and disease by mechanical means (e.g., heat, light, exercise, massage)

physician – individual licensed under state law to practice medicine or osteopathy

physician assistant (PA) – a specially trained and licensed individual who performs tasks usually done by physicians and works under the direction of a supervising physician.

physician associate (PA) group – partnership, association, or corporation composed of two or more physicians and/or nonphysician practitioners who wish to bill Medicare as a unit

PIN – provider identification number

place of service (POS) – where a service is performed, such as a hospital (inpatient or outpatient), doctor’s office, or skilled nursing facility

plan of care – a physician’s written plan stating the kind(s) of service(s) and care a beneficiary needs for his or her health problem

pneumococcal vaccine – a preparation of killed microorganisms, living attenuated organisms, or living fully virulent organisms that is administered to produce or artificially increase immunity to pneumonia

POS – place of service; point of service (Medicare + Choice option)

PPO – preferred provider organization

PPS – prospective payment system

preferred provider organization (PPO) – managed care plan in which the patient uses physicians, hospitals, and providers that belong to a network

premium – the amount a beneficiary regularly pays to Medicare, an insurance company, or a health-care plan for healthcare coverage

preventive care – services to keep a beneficiary healthy or to prevent illness, such as Pap smears, mammograms, prostate and colorectal cancer screenings, and influenza and pneumonia vaccinations

primary payer – insurer (private or governmental) that pays first on a claim for medical care

procedure – an established series of steps used to eliminate a health problem or to learn more about it, such as surgery, tests, and inserting an intravenous line

procedure code – see Current Procedural Terminology (CPT)

professional component – diagnostic test situation where the physician interprets but does not perform the test

prognosis – prediction of a probable course of a disease and the chances of recovery

prosecute – to submit a charging document to a court; seek a grand jury indictment against person(s) accused of committing criminal offenses

prospective payment system (PPS) – mandated by the Balanced Budget Act of 1997 (BBA); changes Medicare payments from cost-based to prospective, based on national average capital costs per case. PPS helps Medicare control its spending by encouraging providers to furnish care that is efficient, appropriate, and typical of practice expenses for providers. Patients and resource needs are statistically grouped, and the system is adjusted for patient characteristics that affect the cost of providing care. A unit of service is then established, with a fixed, predetermined amount for payment.

Prostate cancer screening tests – procedures or tests (e.g., digital rectal exam, prostate specific antigen blood test) for the early detection of prostate cancer

Prostate Specific Antigen (PSA) – blood test, detects marker for adenocarcinoma of the prostate

provider – physician, healthcare professional, hospital, or healthcare facility approved to furnish care to Medicare beneficiaries and to receive payment from Medicare

provider identification number (PIN) – unique individual billing number issued to a provider by the local Medicare contractor, allowing the physician or patient to receive reimbursement for claims filed to the contractor

PSA – prostate specific antigen

purchased diagnostic test – test, such as an EKG, X-ray, or ultrasound, purchased from an outside supplier; the physician does not personally perform or supervise the test

Q

QIO – Quality Improvement Organization

Quality Improvement Organization (QIO) – organization contracting with CMS to review medical necessity and quality of care provided to Medicare beneficiaries

quality assurance – process of looking at how well a medical service is provided; may include formally reviewing healthcare given, locating and correcting the problem, and checking to see if the changes worked

qui tam – the “Whistle Blower,” or “qui tam” provision, allows any person having knowledge of a false claim against the government to bring an action against the suspected wrongdoer on behalf of the United States Government. A person who files a qui tam suit on behalf of the government is known as a “relator” and may share a percentage of the recovery realized from a successful action.

R

referral – specialty, inpatient, outpatient, or laboratory services that are ordered or arranged, but not furnished directly; approval from a beneficiary’s primary or other physician to see a specialist or get certain services

remittance notice – summarized statement for providers, including payment information for one or more beneficiaries

review of systems (ROS) – inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms that the patient may be experiencing or has experienced

regional home health intermediary (RHHI) – organization that contracts with Medicare to pay home health bills and to audit home health physicians

relator – person who files a qui tam suit on behalf of the government; see qui tam or Whistle Blower

reserve days – the nonrenewable, one-time bank of 60 days that a Medicare patient is given to use when the covered days of a spell of illness are exhausted

resident – for Medicare purposes, a physician who is participating in an approved Graduate Medical Education (GME) training program or one who is not in an approved program but who is authorized to practice only in a hospital setting

restitution – court-ordered giving or returning of funds

review – an independent, critical examination of a claim made by carrier personnel not involved in the initial claim determination; the request for a review may be made to the local Medicare carrier by telephone or in writing

RHHI – regional home health intermediary

ROS – review of systems

S

sanction – situation or condition where coverage is disallowed by a subscriber's contract; DHHS/OIG penalty imposed on a provider, prohibiting the individual from billing Medicare or other government programs

sanctioned provider list – OIG list of providers, individuals, and entities that are excluded from Medicare reimbursement; includes identifying information about the sanctioned party, specialty, notice date, sanction period, and sections of the Social Security Act used in arriving at the determination to impose a sanction

screening test – examination for early detection of a specific disease; Medicare pays for specific routine screenings, such as Pap smears, mammograms, prostate cancer screenings, and colorectal cancer screenings

sigmoidoscopy – process of using a sigmoidoscope to examine the sigmoid colon to identify disorders or early signs of cancer

skilled nursing facility (SNF) – institution or distinct part of an institution having a transfer agreement with one or more hospitals; primarily engaged in providing inpatient skilled nursing care or rehabilitation services

SMI – supplemental medical insurance; Medicare Part B; see medical insurance

Social Security Administration (SSA) – federal agency that administers various programs funded under the Social Security Act; determines eligibility for Medicare benefits

supplier – entity that provides medical items or equipment, such as a wheelchair or portable X-ray

supplemental insurance – policy purchased by a beneficiary to help pay charges, such as deductibles, coinsurance, and excluded services, that Medicare does not pay

surrogate UPIN – used if no UPIN has been assigned to the ordering/referring physician; temporary, except those of retired physicians; may be used only until an individual UPIN is assigned

T

technical component – diagnostic test situation where the physician performs the test but does not interpret the results

Title XVIII of the Social Security Act – statutory authority for the Medicare Program

Title XIX of the Social Security Act – statutory authority for the Medicaid Program

treatment – action taken to address or prevent a health problem

TRICARE – the healthcare program for active duty members of the military, military retirees, and their eligible dependents. TRICARE was formerly known as CHAMPUS (Civilian Health and Medical Program of the Uniformed Services).

U

Unique Physician/Practitioner Identification Number (UPIN) – six-character alphanumeric code, assigned by CMS to each Medicare provider and used to identify a referring physician

United States, U.S. – for Medicare coverage purposes, the term United States means the 50 states, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa. For purposes of services furnished on a ship, it includes the territorial waters adjoining the land areas of the United States.

unprocessable claim – claim that cannot be processed due to certain incomplete or incorrect information

UPIN – Unique Physician/Practitioner Identification Number

utilization review – process of verifying medical necessity of services furnished or ordered by a physician or other provider

V

vendor – individual or entity that provides hardware, software, and/or ongoing support services for providers to file claims electronically to Medicare

W

certificate of waiver – issued to a laboratory to perform only waived tests (i.e., simple examinations or procedures that use methodologies that are so simple and accurate that the likelihood of erroneous results is negligible and poses no reasonable risk of harm to the patient if the test is performed incorrectly)

waiver of liability – provision of the Social Security Act, Sections 1842(1) and 1879, that protects the patient from financial liability when Medicare denies or reduces payment for a service or item based on it being considered as “not reasonable and necessary”; under this provision, the patient may not be required to pay the provider for a service, if certain conditions are met

Whistle Blower – the “Whistle Blower,” or “qui tam” provision, allows any person having knowledge of a false claim against the government to bring an action against the suspected wrongdoer on behalf of the United States Government. A person who files a qui tam suit on behalf of the government is known as a “relator” and may share a percentage of the recovery realized from a successful action.

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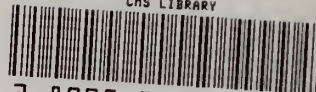
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